

THE FEASIBILITY OF ESTABLISHING A COMMON MEDICAL FEE SCHEDULE FOR WORKERS' COMPENSATION, MOTOR VEHICLE INSURANCE, AND PREPAID HEALTH CARE

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FOREWORD

This report was prepared in response to House Resolution No. 40, H.D. 1, adopted during the Regular Session of 2000. The resolution requests the Legislative Reference Bureau to study the feasibility of having a common medical fee schedule for workers' compensation, motor vehicle insurance, and prepaid health care.

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December 2000

Chapter 1

INTRODUCTION

This study was prepared in response to H.R. No. 40, H.D. 1 (2000), which was adopted by the House of Representatives during the 2000 regular session. The resolution asks the Legislative Reference Bureau to study the feasibility of:

- (1) Establishing a universal medical fee schedule for the prepaid health insurance system, the medical portion of the no-fault automobile insurance system, and the medical portion of the workers' compensation insurance system in Hawaii; and
- (2) Determining universal payment policies, recognized providers, and policies regarding payment for supplies.

In addition, if the Bureau finds it feasible to implement a universal medical fee schedule, the resolution also asks the Bureau to suggest a model universal medical fee schedule. (See Appendix A.)

Restated, the resolution requests the Bureau to study the feasibility of implementing a common medical fee schedule for prepaid health care benefits, motor vehicle insurance personal injury protection benefits, and workers' compensation medical care. The resolution also requests the Bureau to give due accord to the secondary factor of a common payment practice when determining the feasibility of a common fee schedule.

The Bureau finds that it is not feasible to establish a common fee schedule among the three insurance systems. Specifically, the Bureau finds that the federal Employee Retirement Income Security Act of 1974, as amended, will preempt a fee schedule amendment to the Hawaii Prepaid Health Care Act.

The Bureau's analysis is presented in the following chapters.

Chapter 2

THE PROBLEM

Introduction

At first glance, there are four possible ways for prepaid health care, workers' compensation, and motor vehicle insurance to follow a common fee schedule:

- (1) All three follow the prepaid health care fee schedules;
- (2) All three follow the workers' compensation fee schedules;
- (3) All three follow the motor vehicle insurance fee schedules; or
- (4) All three follow an as yet unidentified fee schedule.

However, the present state of the law in Hawaii suggests just two options:

- (1) Prepaid health care follows the workers' compensation medical fee schedules; or
- (2) All three follow an as yet unidentified fee schedule.

The timeline below sets out the statutory events relevant to the present state of the law in Hawaii concerning fee schedules among prepaid health care, workers' compensation, and motor vehicle insurance:

Table 1

FEE SCHEDULE LEGISLATION

Events	Act	Year
Workers' compensation 1971 agency schedule, tied to CPI	78	1973
Prepaid health care, without a fee schedule	210	1974
MV insurance "workers' compensation fee schedules"	123	1992
Work comp Medicare fee schedule	234	1995
MV insurance "workers' compensation supplemental medical fee schedule"	138	2000

The present law in Hawaii regarding fee schedules is discussed in more detail below.

The Present State of the Law in Hawaii

Prepaid Health Care

At present, there are no fee schedules established in the Hawaii Prepaid Health Care Act. Chapter 393, *Hawaii Revised Statutes*, has no provision that sets limits on the charges for services provided by health care providers to employees under a prepaid health care plan.

If there are any fee schedules being used under prepaid health care plans, these fee schedules are being voluntarily adopted for use by the prepaid health care plans themselves. The fee schedules are private sector fee schedules. The prepaid health care plans are not statutorily mandated to use them.

Thus, it is not possible for all three insurance systems to follow the prepaid health care fee schedules, because the prepaid health care law does not provide for statutory fee schedules.

Workers' Compensation

The workers' compensation statutes establish two fee schedules for the payment of medical care, services, and supplies. The main fee schedule is the Medicare fee schedule. Specifically, the applicable fees for workers' compensation are set at one hundred ten per cent of the fees set for Medicare. The other fee schedule is the supplemental fee schedule, intended to supplement products and services not covered, or not reasonably covered, under the Medicare fee schedule. It is supposed to be based on private sector prepaid health care fee schedules.

Section 386-21(c), *Hawaii Revised Statutes*, establishes both fee schedules. The Medicare fee schedule is imposed through the statute. The supplemental fee schedule takes effect through the administrative rules.¹

The federal government publishes the Medicare fee schedule by November each year² in the Federal Register³. Through state statute, the State incorporates the federally-made fee schedule for use in workers' compensation cases. The Medicare fee schedule is applied to workers' compensation cases under the first paragraph of section 386-21(c) as follows:

The liability of the employer for medical care, services, and supplies shall be limited to the charges computed as set forth in this section. The director shall make determinations of the charges and adopt fee schedules based on those determinations. Effective January 1, 1997, and for each succeeding calendar year thereafter, the charges shall not exceed one hundred ten per cent of the fees prescribed in the Medicare Resource Based Relative Value Scale system applicable to Hawaii as prepared by the United States Department of Health and Human Services, except as provided in this subsection. . . .

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1. Hawaii Administrative Rules section 12-15-90.
 2. 42 U.S.C. section 1395w-4(b).
 3. See e.g., Federal Register, Vol. 64, No. 211, November 2, 1999, Final rule, addendum B.

The supplemental fee schedule is also established under section 386-21(c) but requires a state agency to create it through administrative rules. Specifically, the statute authorizes, but does not require the Department of Labor and Industrial Relations to adopt supplemental fee schedules for treatments whose fees are not reasonable under the Medicare fee schedule and for treatments that are not covered by the Medicare fee schedule. The second paragraph of section 386-21(c) reads as follows:

If the director determines that an allowance under the medicare program is not reasonable, or if a medical treatment, accommodation, product, or service existing as of June 29, 1995, is not covered under the medicare program, the director may, at any time, establish an additional fee schedule or schedules not exceeding the prevalent charge for fees for services actually received by providers of health care services to cover charges for that treatment, accommodation, product, or service. If no prevalent charge for a fee for service has been established for a given service or procedure, the director shall adopt a reasonable rate that shall be the same for all providers of health care services to be paid for that service or procedure.

Pursuant to section 386-21(c), *Hawaii Revised Statutes*, the department adopted a supplemental fee schedule through its administrative rules. The supplemental fee schedule is established under Hawaii Administrative Rules section 12-15-90 and is listed in exhibit A, attached to the end of chapter 12-15, Hawaii Administrative Rules, and is entitled “Workers’ Compensation Supplemental Medical Fee Schedule”.

Lastly, under a different statute the department is required to use private sector prepaid health care schedules to the extent possible as the primary guideline in developing the supplemental fee schedule. Specifically, section 386-21.5, *Hawaii Revised Statutes*, requires the Department of Labor and Industrial Relations to request prepaid health care schedules from prepaid health care plan contractors, review those schedules, and to the extent possible use those schedules as the primary guideline in adopting the fee schedule for section 386-21(c). Section 386-21.5 reads as follows:

[§386-21.5] Publication of fees by prepaid health care plan contractors. (a)

A prepaid health care plan contractor as defined in section 393-3 shall provide the director upon request with a schedule of all the maximum allowable medical fees.

(b) Pursuant to section 386-21(c), the director shall review and, to the extent possible, shall use the fee obtained under subsection (a) as the primary guideline in establishing prevalent charges for medical care, services, and supplies in adopting the fee schedule for workers’ compensation claims.

As stated earlier, there is no fee schedule established under the Hawaii Prepaid Health Care Act. Also, the only fee schedule in section 386-21(c) that is subject to adoption is the supplemental fee schedule. The Medicare fee schedule is incorporated directly through statute; it requires no further adoption by the department.

Legislative History of Act 234, Session Laws of Hawaii 1995. The present state of the law regarding the workers’ compensation fee schedules is the result of Act 234, Session Laws of Hawaii 1995. The act repealed the Consumer Price Index-related fee schedule, replaced it with

the Medicare fee schedule, retained the department's authority to adopt supplemental schedules, and required the department to gather prepaid health care fee schedules to use as the primary guideline in adopting a fee schedule under section 386-21(c).

The legislative history of Act 234 indicates that throughout the legislative process the legislative intent was to bring medical fees for work-related injuries into closer conformity with medical fees for non-work related injuries.⁴ The drafts of the bill indicate that throughout the legislative process there was agreement that the schedule adopted by the department in 1971, which was adjusted to increases in the Consumer Price Index, should be repealed. However, there was disagreement over its replacement. During the early stages of the bill, up to the second House draft, the replacement schedule was supposed to be a departmental schedule based primarily on private sector prepaid health care fee schedules. During the later stages of the bill, beginning with the Senate draft, the replacement schedule became the Medicare fee schedule, and the supplemental schedule became the departmental schedule based primarily on the private sector prepaid health care fee schedules.

Motor Vehicle Insurance

Beginning with the year 2000, the motor vehicle insurance statutes establish one fee schedule for the payment of personal injury protection benefits. That fee schedule is the worker's compensation supplemental medical fee schedule. The motor vehicle insurance statutes also supplement that fee schedule with the usual and customary charges method of reimbursement.

The motor vehicle insurance statutes establish the workers' compensation supplemental fee schedule as the motor vehicle insurance fee schedule in section 431:10C-308.5(b), *Hawaii Revised Statutes*, as follows:

The charges . . . for services specified in section 431:10C-103.5(a),⁵ . . . shall not exceed the charges . . . permissible under the workers' compensation supplemental medical fee schedule

The "workers' compensation supplemental medical fee schedule" is defined in section 431:10C-308.5(a) as "the schedule adopted and as may be amended by the director of labor and industrial relations for workers' compensation cases under chapter 386, establishing fees and frequency of treatment guidelines."

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4. See House Standing Committee Report No. 575 and House Standing Committee Report No. 955, House Journal 1995; Senate Standing Committee Report No. 829 and Senate Standing Committee Report No. 899, Senate Journal 1995; Conference Committee Report No. 112, House Journal 1995. The final draft of Act 234 is H.B. No. 2133, H.D. 2, S.D. 1, C.D. 1.
 5. Section 431:10C-103.5(a), *Hawaii Revised Statutes*, defines personal injury protection benefits.

The motor vehicle insurance statutes no longer use the Medicare fee schedule, since the Medicare fee schedule is neither referenced in section 431:10C-308.5(a) nor adopted and amended by the Department of Labor and Industrial Relations.

The motor vehicle insurance statutes supplement the workers' compensation supplemental medical fee schedule with the usual and customary charges method of reimbursement for services if there is no fee set for that service under the fee schedule or under rules adopted by the Insurance Commissioner. Specifically, section 431:10C-308.5(c) states that:

(c) Charges for services for which no fee is set by the workers' compensation supplemental medical fee schedule or other administrative rules adopted by the commissioner shall be limited to eighty per cent of the provider's usual and customary charges for these services.

Thus, motor vehicle insurance and workers' compensation both follow a common fee schedule because both use the workers' compensation supplemental medical fee.

Legislative History of Act 123, Session Laws of Hawaii 1992 and Act 138, Session Laws of Hawaii 2000. Until the year 2000, motor vehicle insurance used both the Medicare fee schedule and the supplemental fee schedule. In other words, there were two common fee schedules used by both motor vehicle insurance and workers' compensation. From 2000, there is only one common fee schedule between them, the supplemental fee schedule.

The present state of the law regarding the motor vehicle insurance fee schedule is the result of the changes that Act 138, Session Laws of Hawaii 2000, made to Act 123, Session Laws of Hawaii 1992.

In 1992, the motor vehicle insurance was amended to adopt the "workers' compensation fee schedules" for use with personal injury protection benefits. Specifically, Act 123, Session Laws of Hawaii 1992, added a new section, 431:10C-308.5, which required the use of the "workers' compensation fee schedules" and defined the schedules as "the schedules adopted and as may be amended by the director of labor and industrial relations for workers' compensation cases under chapter 386 . . .".

The Department of Commerce and Consumer Affairs then implemented section 431:10C-308.5 by adopting both the Medicare fee schedule and the supplemental fee schedule into its administrative rules.⁶ Specifically, the term "medical fee schedule" is defined in its rules as "the Medicare Resource Based Relative Value Scale System applicable to Hawaii and Exhibit A at the end of Title 12, Chapter 15, entitled 'Workers' Compensation Supplemental Medical Fee Schedule.'"⁷ Also, the first sentence of section 16-23-115(a), Hawaii Administrative Rules, reads as follows:

6. Chapter 16-23, subchapter 17, Hawaii Administrative Rules.

7. Hawaii Administrative Rule section 16-23-94.

Charges for medical services shall not exceed one hundred ten per cent of participating fees prescribed in the Medicare Resource Based Relative Value Scale System applicable to Hawaii (Medicare Fee Schedule) or Exhibit A at the end of Title 12, Chapter 15, entitled “Workers’ Compensation Supplemental Medical Fee Schedule” (Exhibit A).

This quoted language reflects the rule as it existed subsequent to its most recent amendment in 1999.

In 2000, the motor vehicle insurance law abandoned the workers’ compensation Medicare fee schedule but retained the workers’ compensation supplemental medical fee schedule. Specifically, Act 138, Session Laws of Hawaii 2000, amended section 431:10C-308.5 by replacing the term “workers’ compensation schedules” with the term “workers’ compensation supplemental medical fee schedule.” The supplemental medical fee schedule literally does not include the Medicare fee schedule.

The legislative intent of Act 138 with regard to the fee schedules was to create “a uniform reference to the Workers’ Compensation Supplemental Medical Fee Schedule.”⁸ The act is based on a draft of a bill submitted by the Department of Commerce and Consumer Affairs.⁹ In its justification sheet attached to the draft, the department stated that “Article 10C currently refers to the ‘workers’ compensation schedules’ or the ‘applicable fee schedule codes’. This bill would provide a uniform reference to the ‘workers’ compensation supplemental medical fee schedule’ as it is currently known.”

The stated intent of the act differs significantly from its literal effect. The uniform reference to the supplemental fee schedule in effect repeals the use of the Medicare fee schedule. Until Act 138, motor vehicle insurance shared two fee schedules in common with workers’ compensation: the Medicare fee schedule and the supplemental schedule. Pursuant to Act 138, motor vehicle insurance will share only one common fee schedule: the supplemental schedule.

The Options in Implementing a Common Fee Schedule

Among the four possible options for implementing a common fee schedule among workers’ compensation, motor vehicle insurance, and prepaid health care, two options can be eliminated. First, the option of having all three insurance systems follow the prepaid health care fee schedules can be eliminated. There are no fee schedules established in the prepaid health care statutes. Second, the option of having all three insurance systems follow the motor vehicle insurance fee schedules can also be eliminated. Motor vehicle insurance has no unique fee schedule of its own. It merely follows one of the two workers’ compensation fee schedules, specifically, the workers’ compensation supplemental medical fee schedule.

8. Conference Committee Report No. 37, on H.B. No. 2476, H.D. 1, S.D. 2, C.D. 1.

9. CCA-14(00).

There are two remaining options. One requires a comment. Workers' compensation has two fee schedules. Formerly, both were used as well in motor vehicle insurance. From now, however, based on the plain meaning of Act 138, Session Laws of Hawaii 2000, it appears that only the supplemental fee schedule will be used in motor vehicle insurance. In other words, both workers' compensation and motor vehicle insurance once followed the exact same set of fee schedules. If prepaid health care could be made to follow that same set of fee schedules, then all three insurance systems -- prepaid health care, workers' compensation, and motor vehicle insurance -- would follow that same set of fee schedules. There would then be a set of common fee schedules used by all three insurance systems.

In other words, Act 138, Session Laws of Hawaii 2000, is at odds with H.R. No. 40, H.D. 1, adopted in the same 2000 Regular Session. The act moves motor vehicle insurance away from the use of fee schedules by eliminating the use of the Medicare fee schedule. The resolution seeks the use of common fee schedules for the three insurance systems, including motor vehicle insurance.

Pursuing a set of common fee schedules for the three insurance systems lacks a certain element of seriousness if the Medicare fee schedule is eliminated from consideration. The Medicare fee schedule is a far more extensive fee schedule than the supplemental fee schedule. The Medicare fee schedule lists about 16,362 separate codes and descriptions.¹⁰ The supplemental fee schedule lists about 286-305 separate codes and descriptions.¹¹

Accordingly, for the analytical purposes of this report, Act 138 will be ignored. While Act 138 is obviously relevant, it is not critical to determining the feasibility of establishing a common schedule. If the Legislature decides to commit itself to the use of common fee schedules for the three insurance systems, then Act 138 can be undone in order to reinstate the Medicare fee schedule into the motor vehicle insurance laws.

Given the present state of the law in Hawaii and ignoring Act 138, the two options that can be pursued to implement a common fee schedule among the three insurance systems are restated as follows:

- (1) Prepaid health care follows the workers' compensation fee schedules, which are comprised of both the Medicare fee schedule and the workers' compensation supplemental medical fee schedule; or
- (2) Workers' compensation, motor vehicle insurance, and prepaid health care all follow a different fee schedule.

The easier option to implement is the first one. The two fee schedules are already made, and the only law that needs to be amended would be the prepaid health care law, or other laws that could make such a fee schedule apply to prepaid health care. The second option is more difficult to

10. Federal Register, Vol. 64, No. 211, November 2, 1999, Final rule, addendum B.

11. Workers' Compensation Supplemental Medical Fee Schedule, Hawaii Administrative Rules chapter 12-15, exhibit A, January 1, 1997.

THE PROBLEM

implement. A different fee schedule needs to be made or found, and all three laws need to be amended.

Thus, the original and primary request in H.R. No. 40, H.D. 1, can be rephrased even more simply as follows:

Determine the feasibility of implementing the workers' compensation fee schedules in prepaid health care.

This is the issue that will be taken up in the remainder of the study.

Chapter 3

WORKERS' COMPENSATION FEE SCHEDULES FOR PREPAID HEALTH CARE

Implementing the workers' compensation fee schedules in the Hawaii Prepaid Health Care Act requires an amendment to chapter 393, *Hawaii Revised Statutes*. For the purposes of discussion, the presumptive means of imposing this new requirement would be to add a new section to the prepaid health care law along the following lines:

§393-A Medical fee schedule. The charges for health care benefits shall not exceed one hundred ten per cent of participating fees prescribed in the Medicare Resource Based Relative Value Scale System applicable to Hawaii (Medicare Fee Schedule) or Exhibit A at the end of Title 12, chapter 15, entitled "Workers' Compensation Supplemental Medical Fee Schedule" (Exhibit A).

This amendment is based on section 16-23-115(a), Hawaii Administrative Rules (Department of Commerce and Consumer Affairs), prior to the enactment of Act 138, Session Laws of Hawaii 2000. The proposed amendment will enable the prepaid health care system to follow the same set of common medical fee schedules that were once followed by both workers' compensation and motor vehicle insurance, prior to Act 138.

The fee schedules ultimately set forth two basic items of information: a treatment and its maximum charge. If a treatment is listed under either fee schedule, a health care provider may not charge a patient more than the maximum charge allowable for that particular treatment. It is assumed in this study that the mere listing of a treatment in either fee schedule is not a mandate that such a treatment must be covered under a prepaid health care plan. In other words, the fee schedule amendment is not construed to be a mandated benefits amendment. This assumption is supported by language in H.R. No. 40, H.D. 1, that the establishment of a common fee schedule will not require the insurer to cover benefits that it does not already provide.

The maximum charge is calculated differently depending on whether the treatment is listed under the Medicare fee schedule or under the supplemental fee schedule.

If the treatment and its code are listed under the supplemental fee schedule, the calculation of the maximum charge is relatively simple. The maximum charge is the product of the unit value specified for that treatment code multiplied by \$33.54.¹

As an example, treatment code 90724, is for the influenza virus vaccine. Its unit value is 0.5. Accordingly, the maximum charge allowed under the supplemental fee schedule for immunization against the influenza virus is as follows: $(0.5) * (\$33.54) = \16.77 .

1. Hawaii Administrative Rules chapter 12-15, January 1, 1997 preface.

On the other hand, if the treatment and its code are listed under the Medicare fee schedule, the calculation is a little more complicated. The version of the Medicare fee schedule of treatments and charges reviewed in this report was from the November 2, 1999 edition of the Federal Register, Vol. 64, No. 211. The fee schedule lists codes and data in tabular form from which it becomes possible to calculate a charge for a particular medical procedure.

To calculate a charge for a treatment under the Medicare fee schedule, it is necessary to apply data from the tables to the statutorily prescribed mathematical formula for the charge. Under 42 U.S.C. section 1395w-4(b), the payment amount for a physician's service is equal to the product of three factors: the payment amount = (the relative value for the service) * (conversion factor) * (geographic adjustment factor).

The relative value of the physician's service is composed of a work component, a practice expense component, and a malpractice component.² The methodology for combining these components to produce a single relative value for a service is left to the Secretary of Health and Human Services.³ It appears that the methodology for combining these components is to add them together. Furthermore, the practice expense component has four possible values. The specific value of the practice expense component depends on whether the service is provided at a facility or at a non-facility, and whether the facility or non-facility is transitional or fully implemented.⁴ Accordingly, the relative value of the physician's service also has four possible specific values.

The conversion factor for the 2000 physician fee schedule is \$36.6137.⁵

The geographic adjustment factor is the sum of three adjustment factors: the geographic cost-of-practice adjustment factor, the geographic malpractice adjustment factor, and the geographic physician work adjustment factor.⁶ For Hawaii in the years 1999-2000, the physician work factor is 0.998. The cost-of-practice factor is 1.183. The malpractice factor is 0.954.⁷ Thus, the geographic adjustment factor for Hawaii during 1999-2000 is the sum of those three quantities: $0.998 + 1.183 + 0.954 = 3.135$.

Under the Medicare fee schedule, the payment amount for a physician's service in Hawaii during 1999-2000 is thus equal to the product of the following three factors: payment amount = (the relative value for the service) * (\$36.6137) * (3.135).

Finally, when used in workers' compensation and as a hypothetical common fee schedule for motor vehicle insurance and prepaid health care, the Medicare fee schedule for Hawaii during 1999-2000 is raised by ten per cent. Accordingly, the maximum charge for a physician's service

2. 42 U.S.C. section 1395w-4(c)(1).

3. 42 U.S.C. section 1395w-4(c)(2)(A)(i).

4. Federal Register, Vol. 64, No. 211, November 2, 1999, Final rule, addendum B, page 59443.

5. Federal Register, Vol. 64, No. 211, November 2, 1999, Final rule, part V, page 59429.

6. 42 U.S.C. section 1395w-4(e)(2).

7. Federal Register, Vol. 64, No. 211, November 2, 1999, Final rule, addendum D, page 59583.

under the hypothetical common fee schedule would be equal to the product the Medicare payment amount multiplied by 1.10. Stated otherwise, the maximum charge under the common fee schedule equals $(1.10) * (\text{the Medicare payment amount})$. Or, the common fee schedule maximum charge equals $(1.10) * (\text{the relative value for the service}) * (\$36.6137) * (3.135)$.

Sample Calculation Using the Medicare Fee Schedule. As an example, the first listed treatment under addendum B on relative value units is CPT 10040 for acne surgery of skin abscess. The physician work relative value is 1.18. The malpractice relative value is 0.05.

The practice expense relative value has the following four possible values:

1.57 for a fully implemented non-facility;

0.96 for a year 2000 transitional non-facility;

0.52 for a fully implemented facility; and

0.35 for a year 2000 transitional facility.

The relative value of the service is the sum of three components. Since one of its components, the practice expense, has four possible values, the relative value of the service also has four possible values as follows:

$1.18 + 0.05 + 1.57 = 2.80$ for a fully implemented non-facility;

$1.18 + 0.05 + 0.96 = 2.19$ for a year 2000 transitional non-facility;

$1.18 + 0.05 + 0.52 = 1.75$ for a fully implemented facility; and

$1.18 + 0.05 + 0.35 = 1.58$ for a year 2000 transitional facility.

The Medicare payment amount is the product of three components. One of its components, the relative value of the service, has four possible values. Accordingly, the Medicare payment amount also has four possible values as follows:

$2.80 * \$36.6137 * 3.135 = \321.39 for a fully implemented non-facility;

$2.19 * \$36.6137 * 3.135 = \251.38 for a year 2000 transitional non-facility;

$1.75 * \$36.6137 * 3.135 = \200.87 for a fully implemented facility; and

$1.58 * \$36.6137 * 3.135 = \181.36 for a year 2000 transitional facility.

Finally, the maximum charge allowed under the hypothetical common fee schedule is one hundred ten per cent of the Medicare payment amount. The Medicare payment amount has four

possible values. Accordingly, the maximum charge under the hypothetical common fee schedule also has four possible values as follows:

$1.10 * \$321.39 = \353.53 for a fully implemented non-facility;

$1.10 * \$251.38 = \276.52 for a year 2000 transitional non-facility;

$1.10 * \$200.87 = \220.96 for a fully implemented facility; and

$1.10 * \$181.36 = \199.50 for a year 2000 transitional facility.

The Factor of Payment Practices Under a Common Fee Schedule

H.R. No. 40, H.D. 1, requests the Bureau to give due accord to the secondary factor of a common payment practice when determining the feasibility of a common fee schedule. The resolution specifically lists payment policies, recognized providers, and policies regarding payment for supplies. The Bureau gives due accord to that matter in this section.

In setting a maximum charge for a treatment, the fee schedule provisions in the workers' compensation and motor vehicle insurance laws apparently also affect the relationship among the health care provider, the patient, and the insurer with regard to that maximum charge. In particular, the common fee schedules appear to be accompanied by common payment practices. The fee schedules for workers' compensation and motor vehicle insurance contain the following points in common with regard to payment practices:

- (1) The provider charges no more than the fee schedule amount.
 - (a) WC HRS section 386-21(c)
 - (b) MV HRS section 431:10C-308.5(b)
- (2) The insurer pays no more than the fee schedule amount.
 - (a) WC HRS section 386-21(c)
 - (b) MV HRS section 431:10C-308.5(b)
- (3) The provider may not charge the patient for the difference between the provider's full charge and the amount paid under the fee schedule.
 - (a) WC HRS section 386-21(a), (c)

- (b) MV HRS section 431:10C-308.5(f)⁸
- (4) The insurer reimburses the provider directly.
 - (a) WC HRS section 386-21(f)
 - (b) MV HRS sections 431:10C-304(l), 10C-308.5(e)

All but item (4) deal with the amount of payment charged by the provider or paid by the insurer. Item (1) is the crucial defining characteristic of a fee schedule. There is, in effect, no real fee schedule if a provider can charge more than the maximum amount allowed under the fee schedule. The provider may only charge an amount less than or equal to that maximum allowable fee schedule amount.

Item (2) follows from item (1). The insurer pays no more than what the provider charged.

Item (3) reinforces the notion that the fee schedule sets a schedule of maximum charges, not a schedule of guaranteed charges. Item (3) addresses situations in which the insurer actually pays the provider less than what the provider charged. Item (3) prohibits the provider from charging the insured for the balance. Item (3) evidently gives the insurer some latitude in determining the extent to which the provider will receive the amount that the provider charged, whether the amount is less than or equal to the maximum fee amount allowed under the fee schedule. Stated otherwise, item (3) provides a check against the provider's always charging and receiving the maximum fee allowed under the fee schedule.

Items (1) to (3) are common payment practices that appear to define the idea of a fee schedule. Accordingly, it is assumed that they will be made to apply to any fee schedules established in the Hawaii Prepaid Health Care Act.

Item (4) is a direct reimbursement requirement. It is distinct from the others because it deals not so much with the payment amount itself but rather with the manner in which payment is made. The issue of direct reimbursement is disposed of here, in order to streamline the ERISA discussion in the subsequent chapters, which focuses on the payment practices surrounding the fee schedule amount. According to a district court in the Eleventh Circuit of the United States Court of Appeals, of which Hawaii is not a part, the federal Employee Retirement Income

8. Section 431:10C-308.5(f), *Hawaii Revised Statutes*, actually reads in pertinent part: "The provider shall not bill or otherwise attempt to collect from the insured the difference between the provider's full charge and the amount paid by the insurer." In motor vehicle insurance, the insurer may require the insured to make co-payments to the provider, section 431:10C-103.6(e). Since the co-payment is paid by the insured rather than the insurer, the statute seems to literally prohibit the provider from collecting the co-payments. Accordingly, it seems that the amount that the provider cannot collect from the insured should be the difference between the provider's full charge on the one hand, and the combined amount paid by both the insurer and the insured on the other. That combined amount is the amount paid under the fee schedule.

Security Act of 1974 preempts direct payment statutes that relate to employee benefit plans. The reason is that the statutes are not laws that regulate insurance so as to be saved from preemption.⁹ Accordingly, it will not be assumed that direct reimbursement is a payment practice that governs the use of a fee schedule in the Hawaii Prepaid Health Care Act.

A payment practice that was not common to both workers' compensation and motor vehicle insurance is the insurer practice of requiring the insured to make co-payments to the provider. Workers' compensation does not allow the practice¹⁰, but motor vehicle insurance does allow it¹¹. For this study, it is assumed that co-payments will be permitted in the use of a fee schedule under the Hawaii Prepaid Health Care Act.

Summary of Assumptions

The assumptions made in this study relating to the use of the proposed fee schedules in the Hawaii Prepaid Health Care Act are summarized as follows:

- (1) The proposed fee schedules do not mandate the coverage of treatments that are not already required under a prepaid health care plan;
- (2) Except for the practice of direct reimbursement, the other common payment practices governing the use of the common fee schedules in workers' compensation and motor vehicle insurance also govern the use of the proposed fee schedules in prepaid health care. Specifically:
 - (a) The provider charges no more than the fee schedule amount;
 - (b) The insurer pays no more than the fee schedule amount; and
 - (c) The provider may not charge the patient for the difference between the provider's full charge and the amount paid under the fee schedule;and
- (3) The insurer may require the insured to make co-payments.

9. See *Hayden v. Blue Cross and Blue Shield of Alabama*, 843 F. Supp. 1427, 1431-1436 (M.D. Ala. 1994).

10. Section 386-21(a), *Hawaii Revised Statutes*.

11. Section 431:10C-103.6(e), *Hawaii Revised Statutes*.

Chapter 4

ERISA ANALYSIS OF A FEE SCHEDULE AMENDMENT TO THE HAWAII PREPAID HEALTH CARE ACT

Introduction

The issue examined in this chapter is whether the workers' compensation fee schedules may be established directly in the Hawaii Prepaid Health Care Act itself. In other words, the issue is whether chapter 393, *Hawaii Revised Statutes*, may be amended to subject health care providers to the charges prescribed in both the Medicare and the supplemental fee schedules.

A legal obstacle in establishing fee schedules in the prepaid health care statutes is the federal Employee Retirement Income Security Act of 1974, as amended. The federal act generally preempts any state law that relates to an employee benefit plan, unless the state law is protected by an exemption. Thus, there is a legal issue of whether ERISA permits the establishment of fee schedules in the Hawaii Prepaid Health Care Act.

The ERISA analysis and conclusions are set out in brief as follows:

- (1) Does the fee schedule amendment "relate to" an employee benefit plan?

Yes, it does, because the entire Hawaii Prepaid Health Care Act itself relates to an employee benefit plan.

- (2) If the fee schedule amendment "relates to" an employee benefit plan, is there an exemption that may apply?

Yes, there is a specific exemption for the Hawaii Prepaid Health Care Act and some of its amendments.

- (3) If there is an exemption that applies, does the exemption save the fee schedule amendment from preemption?

No, because the fee schedule amendment does not fit into the exemption.

Thus, we believe that it is not legally permissible under ERISA to establish a fee schedule in the Hawaii Prepaid Health Care Act.

We present our analysis below. In doing so, we also discuss the purpose of ERISA, its preemption of state laws, the exemption for the Hawaii Prepaid Health Care Act, the Hawaii Prepaid Health Care Act itself, its amendments, and the proposed fee schedule amendment in contrast to the Act and its amendments.

Does the Fee Schedule Amendment “Relate to” an Employee Benefit Plan?

The ERISA Preemption of State Laws

The Employee Retirement Income Security Act of 1974 (“ERISA”) is a federal act that took effect on September 2, 1974.¹ A basic stated purpose of ERISA is to protect participants in employee benefit plans and their beneficiaries. The federal act protects them by requiring plans to make financial disclosures and reports, by requiring plan fiduciaries to follow standards of conduct, and by enforcing those requirements through remedies, sanctions, and access to the federal courts.²

ERISA accomplishes its purposes in part by preempting state laws that relate to employee benefit plans. The preemption language of ERISA, at 29 U.S.C. section 1144(a), reads as follows:

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

In plain words, the ERISA provisions on the protection of employee benefit rights and on plan termination insurance will generally preempt state laws if those state laws relate to private sector employee welfare benefit plans. Employee welfare benefit plans include plans that provide participants, through the purchase of insurance, medical, surgical, or hospital care or benefits. They include employee group health insurance plans. ERISA does not preempt state laws relating to public sector plans because public sector plans are exempt from ERISA coverage.³

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1. Public Law No. 93-406, U.S.S.C.A.N. 1974, Vol 1, 93rd Congress 2d Session. ERISA is codified under chapter 18 of title 29 on labor in the United States Code.
 2. 29 U.S.C. section 1001(b).
 3. The technical terms and references in 29 U.S.C. section 1144(a), the preemption provision, are defined as follows:
 - (1) “This subchapter” is subchapter I, which deals with the protection of employee benefit rights, applies to all private sector employee benefit plans established or maintained by employers or employee organizations, or both. 29 U.S.C. section 1003(a). Specifically, private sector employee benefit plans must follow ERISA requirements on reporting and disclosure, participation and vesting, funding, fiduciary responsibility, administration and enforcement, continuation coverage and additional standards for group health plans, and group health plan requirements. Governmental plans are expressly exempt. 29 U.S.C. section 1003(b);
 - (2) “Subchapter III” deals with plan termination insurance. Specifically, subchapter III covers the pension benefit guaranty corporation, employer withdrawals, merger or transfer of plan
- (Footnote continued on next page.)*

According to the United States Supreme Court, the congressional intent behind the preemption clause is to:

. . . ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.⁴

According to the Supreme Court, Congress intended to establish the regulation of employee welfare benefit plans “as exclusively a federal concern.”⁵

The Hawaii Prepaid Health Care Act “Relates to” an Employee Benefit Plan

There is a test developed by the United States Supreme Court in its opinions to determine whether a state law “relates to” an employee benefit plan, and is therefore subject to preemption by ERISA.

assets or liabilities, reorganization, minimum contribution requirement for multiemployer plans, financial assistance, benefits after termination, and enforcement;

- (3) “State laws” include all laws, decisions, rules, regulations, or other state action having the effect of law, of any state. 29 U.S.C. section 1144(c)(1);
 - (4) “Employee benefit plan”, defined at 29 U.S.C. section 1002(3), is either an employee welfare benefit plan or an employee pension benefit plan, or a plan that is both an employee welfare benefit plan and an employee pension benefit plan. An “employee pension benefit plan” in turn is defined at 29 U.S.C. section 1002(2)(A) as a plan that provides retirement income to employees or defers their income until or beyond the termination of their employment;
 - (5) An “employee welfare benefit plan” is defined at 29 U.S.C. section 1002(1) to include a plan that provides “participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits . . .”;
 - (6) A participant, at 29 U.S.C. 1002(7), refers to an employee or former employee eligible to receive benefits from an employee benefit plan; and
 - (7) The employee benefit plans “described in section 1003(a) of this title” are the private sector plans. The employee benefit plans “exempt under section 1003(b) of this title” include, but are not limited to, the governmental plans of the federal government, the states, and the political subdivisions of the states.
- 4. New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 657 (1995), quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990).
 - 5. New York State Conference of Blue Cross and Blue Shield Plans, 514 U.S. at 656, quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981).

However, the test is moot for the Hawaii Prepaid Health Care Act and its amendments. In 1980 the federal Ninth Circuit Court of Appeals ruled in *Standard Oil Co. of California v. Agsalud* that the entire Act “relates to” an employee benefit plan, fits no exemption, and is thus preempted by ERISA.⁶

Is There an Exemption that May Apply?

Yes, there is.

The Exemption for the Hawaii Prepaid Health Care Act

There is a limited but specific exemption in ERISA that applies only to the Hawaii Prepaid Health Care Act and some of its amendments. It was granted by Congress in 1982. The exemption repeals the ninth circuit court of appeal’s 1980 Standard Oil ruling.

The Hawaii Prepaid Health Care Act exemption is found at 29 USC section 1144(b)(5), and reads as follows:

- (5)
- (A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. Sec. 393-1 through 393-51).
 - (B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section –

...
 - (ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.
 - (C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such parts 1 and 4 and the preceding sections of this part.

6. *Standard Oil Co. of California v. Agsalud*, 633 F.2d 760 (9th Cir 1980), aff’d 454 U.S. 801 (1981). The ruling affirmed *Standard Oil of California v. Agsalud*, 442 F.Supp. 695 (N.D. Cal 1977).

In plain words, the exemption has three parts to it. First, the exemption saves the original Act from preemption. Second, it permits amendments to the original act that involve no more than the effective administration of the original Act. ERISA otherwise preempts amendments that provide for more than the effective administration of the original Act. Third, the exemption does not save the Hawaii act from preemption in areas involving reporting and disclosure and fiduciary responsibility. ERISA preempts them.⁷

The three parts of the exemption are explained in more detail below.

Under the first part, ERISA exempts the entire Hawaii Prepaid Health Care Act in the form in which the Hawaii Prepaid Health Care Act existed on September 2, 1974. This is the date on which ERISA took effect.⁸ The form in which the Hawaii Prepaid Health Care Act existed on September 2, 1974 is identical to the form in which the Act took effect. The Hawaii Prepaid Health Care Act took effect on June 12, 1974.⁹ There were no amendments at all to the Act between the two dates. The form in which the Act existed on September 2, 1974 is that of the original Act itself. Thus, ERISA exempts the original Act.

Under the second part, ERISA permits amendments to the Hawaii Prepaid Health Care Act enacted after September 2, 1974 only if the amendments do no more than provide for the effective administration of the Act as it existed on September 2, 1974. In other words, ERISA permits amendments to the original Act only if they do no more than provide for the effective administration of the original Act. If those amendments to the Act provide for more than the effective administration of the Act, then they are preempted by ERISA.

According to the federal district court for the District of Hawaii, Congress intended the term “effective administration” to be construed strictly. The ERISA amendment as a whole was

7. The technical terms and references in 29 U.S.C. section 1144(b)(5), the exemption provision, are defined as follows:

- (1) “Subsection (a) of this section” means the general rule of preemption, in 29 U.S.C. section 1144(a); and
- (2) “The provisions of such parts 1 and 4 of this subtitle” refer to provisions that deal with reporting and disclosure and to provisions that deal with fiduciary responsibility. Specifically, the reporting and disclosure provisions in part 1 require the administrator of an employee benefit plan to make reports and disclosures to participants and beneficiaries of the plan and to the federal government. The fiduciary responsibility provisions in part 4 involve the designation, qualifications, standard of care, prohibited transactions, and liability for breach of duty of plan fiduciaries and plan asset trustees.

8. Employee Retirement Income Security Act of 1974, Public Law No. 93-406, U.S.S.C.A.N. 1974, Vol. 1, 93rd Congress 2d Session.

9. Act 210, Session Laws of Hawaii 1974.

to operate only as a narrow exception.¹⁰ Thus, an amendment “provides for more than the effective administration of such Act” if it constitutes a substantive change.¹¹

Under the third part, ERISA nonetheless preempts, from January 14, 1983 onward, any provisions of the Hawaii Prepaid Health Care Act with respect to matters governed by the reporting and disclosure and the fiduciary responsibility provisions of ERISA. Reporting and disclosure provisions in ERISA involve reports and disclosures that the administrator of an employee benefit plan is required to make to participants and beneficiaries of the plan and to the federal government. Fiduciary responsibility provisions in ERISA involve the designation, qualifications, standard of care, prohibited transactions, and liability for breach of duty of plan fiduciaries and plan asset trustees.

Does the Exemption Save the Fee Schedule Amendment from Preemption?

Based upon the three parts to the Hawaii Prepaid Health Care Act exemption, a test for determining whether a provision of the Hawaii Prepaid Health Care Act will be saved or preempted under ERISA can be formulated as follows, along with the answers applicable to a proposed fee schedule:

- (1) Is the provision a part of the original Hawaii Prepaid Health Care Act that was in effect on September 2, 1974 or is it an amendment to the Act?
 - (a) If it is part of the original Act, then the provision is exempt from preemption;
 - (b) If it is an amendment, then go to the next question;

Answer: The fee schedule provision is an amendment.

- (2) Does the amendment provide for more than the effective administration of the Prepaid Health Care Act as it existed on September 2, 1974?
 - (a) If it does, then the amendment is preempted by ERISA;
 - (b) If it does not, then go to the next question;

Answer: The fee schedule amendment provides for more than the effective administration of the Act as it existed on September 2, 1974.

- (3) Does the amendment govern matters that are governed by ERISA provisions on reporting and disclosure or on fiduciary responsibility?

10. Council of Hawaii Hotels v. Agsalud, 594 F.Supp. 449, 455 (D. Hawaii 1984).

11. Council of Hawaii Hotels, 594 F.Supp. at 452.

- (a) If it does, then the amendment is preempted by ERISA;
- (b) If it does not, then the amendment is saved from preemption.

Answer: The fee schedule amendment does not deal with reporting and disclosure or fiduciary responsibility.

The first issue is not a concern. The fee schedule provision is not a part of the Act as it existed on September 2, 1974. The fee schedule provision is an amendment.

The third issue, if arrived at, does not appear to be a concern either, as the fee schedule amendment does not govern reporting and disclosures and fiduciary responsibility. The fee schedule amendment is unrelated to reports and disclosure to participants, beneficiaries, or the federal government. The fee schedule amendment is also unrelated to the designation, qualifications, standard of care, prohibited transactions, or liability for breach of duty of plan fiduciaries and plan asset trustees.¹²

However, it is the second issue that is a concern. The narrow exemption requires a strict construction of the term “effective administration”. The fee schedule amendment in question provides for more than the effective administration of the Act as it existed on September 2, 1974. It is substantive. It departs from the basic purpose and principles of the Hawaii Prepaid Health Care Act as it existed on September 2, 1974. The proposed fee schedule amendment creates new duties and imposes some on an entity that is outside the scope of the original Act. It also bears little resemblance to the prior amendments to the Act, both those that are preempted and those that are not.

The analysis under the second issue, relating to “effective administration”, is presented in the next chapter.

12. An example of a state law that relates to reporting and disclosure and is therefore preempted is the version of section 12-12-28, Hawaii Administrative Rules, discussed in *Snider v. Crimson Enterprises, Inc.*, 768 F.Supp. 734, 740 (D.Hawaii 1991), at note 4: the administrative rule required notice to employees of cancellation of all statutorily required insurance policies; therefore, the rule is preempted by ERISA.

Chapter 5

ANALYZING THE FEE SCHEDULE AMENDMENT UNDER THE ERISA EXEMPTION FOR THE HAWAII PREPAID HEALTH CARE ACT

Introduction

This chapter is a continuation of the previous chapter. Here, the fee schedule amendment (*i.e.*, an amendment to the Hawaii Prepaid Health Care Act that would subject health care providers to the charges prescribed in the Medicare and supplemental fee schedules) is analyzed under the specific ERISA exemption for amendments to the Hawaii Prepaid Health Care Act. The issue to be resolved is whether the fee schedule amendment provides for more than the effective administration of the Act as it existed on September 2, 1974. An amendment that provides for not more than “effective administration” is saved from preemption. An amendment that provides for more than “effective administration” is preempted.

As stated in the previous chapter, the federal District Court for the District of Hawaii has stated that the exemption is a narrow one, and the term “effective administration” must be strictly construed.¹ Accordingly, an amendment that makes substantive changes is an amendment that provides for more than “effective administration”.²

In order to determine whether the fee schedule amendment provides for not more than the “effective administration” of the original Act, the amendment is examined against the basic purposes and principles of the original Prepaid Health Care Act and contrasted with the other amendments to the Act.

The Hawaii Prepaid Health Care Act

The Hawaii Prepaid Health Care Act, as it existed on September 2, 1974, requires the employer to cover his employees under a group health care plan. The “employer” is a private sector employer, not a government employer.³ The act can be summarized as follows:

- (1) An employer must provide his regular employees with coverage under a prepaid group health care plan with a prepaid health care plan contractor;⁴

1. Council of Hawaii Hotels v. Agsalud, 594 F.Supp. 449, 455 (D. Hawaii 1984).

2. Council of Hawaii Hotels, 594 F.Supp. at 452 (D. Hawaii 1984).

3. Act 210, Session Laws of Hawaii 1974, new section -3(3).

4. Act 210, section 1 (-11).

- (2) The group health care plan must provide certain minimum mandatory health care benefits;⁵

The stated purpose of the Act is to extend to unprotected workers the protection of prepaid health care plans against the costs of medical care. Unprotected workers were those who did not already enjoy health care coverage through collective bargaining agreements, employer-sponsored plans, or individual initiative. Without such protection the cost of medical care in case of sudden need might consume all or an excessive part of a person's resources.⁶

Under the Act, the employer must provide his regular employees with coverage under a prepaid group health care plan with a prepaid health care plan contractor.⁷ The health care plan is an agreement between the employer and the plan contractor made for the benefit of the employee. The employer chooses one of two types of plan contractors.⁸ One type is a medical group or organization that undertakes under a prepaid health care plan to provide health care. The other type is a nonprofit organization or insurer that undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care.⁹

Thus, depending on the type of contractor selected, the prepaid health care plan contractor then undertakes in consideration of a premium either to furnish health care or to defray or reimburse the expenses of health care. Health care includes hospitalization, surgery, medical or nursing care, or drugs or other restorative appliances.¹⁰

Both the employer and the employee contribute toward the payment of the premium for coverage.¹¹ An employer is entitled to premium supplementation from the State if the employer has few employees and the cost of providing them coverage is relatively high.¹²

In summary, the employer owes his employees health care coverage. The employer contracts with the plan contractor to provide that coverage. The plan contractor either furnishes the employee with health care or defrays or reimburses the employee's health care expenses. In consideration of the coverage, both the employer and the employee pay the contractor a premium.

5. *Id.*, section 1 (-7).

6. *Id.*, section 1 (-2).

7. *Id.*, section 1 (-11).

8. *Id.*, section 1 (-12).

9. *Id.*, section 1 (-3(7)).

10. *Id.*, section 1 (-3(6)).

11. *Id.*, section 1 (-13).

12. *Id.*, section 1 (-45).

The Fee Schedule Amendment in the Context of the Original Act

The fee schedule amendment potentially shares some of the same legislative policy of the Hawaii Prepaid Health Care Act as it existed on September 2, 1974. The policy behind the Act is to protect employees against the costs of medical care. The Act serves this policy by requiring employers to provide employees with health insurance.

Likewise, the fee schedule amendment can be perceived as serving the same overall policy. The Medicare and supplemental fee schedules protect employees against the costs of medical care by imposing ceilings on health care provider charges. Health care providers can charge no more than the amounts under the fee schedules, and are required to accept no more than the amounts provided to them under those fee schedules. Thus, the fee schedules are a kind of sequel to mandatory health care coverage. In protecting employees against the costs of medical care the first step was health insurance coverage. The second step is controlling the costs of that medical care.

However, under a strict construction of the ERISA exemption, an amendment that provides for not more than the effective administration of the Act as it existed on September 2, 1974 does not include substantive amendments.¹³ A substantive law creates duties, rights, and obligations.¹⁴

There are at least two reasons why the fee schedule amendment is a substantive amendment, in other words, an amendment that provides for more than the effective administration of the Act.

First, the amendment impacts the health care provider, an entity that is not regulated under the Act as it existed on September 2, 1974. The health care provider is not defined, addressed, or mentioned in the original Act. The amendment impacts the provider by subjecting the provider to a ceiling on the provider's charges. It prohibits the provider from charging more than the amounts prescribed for the specific treatments listed under either the Medicare fee schedule or the workers' compensation supplemental medical fee schedule. It also requires the provider to accept payment under the fee schedules as payment in full.

Second, the amendment imposes a new duty on the prepaid health care plan contractor, an entity covered under the original Act. The amendment requires the contractor to use both the Medicare fee schedule and the workers' compensation supplemental medical fee schedule in reimbursing providers for the listed treatments. The requirement is two-tiered. First, of all possible methods of reimbursement, the contractor must use the fee schedule method. The method of usual, customary, and reasonable charges may not be used. Second, of all possible fee schedules, the contractor must use only the Medicare fee schedule and the workers' compensation supplemental medical fee schedule. Any other fee schedule developed by governmental or private entities may not be used.

13. Council of Hawaii Hotels v. Agsalud, 594 F.Supp. 449, 452 (D. Hawaii 1984).

14. Black's Law Dictionary Fifth Edition.

Comparing the Fee Schedule Amendment with Past Amendments to the Act

To reinforce the conclusion that the proposed fee schedule amendment provides for more than the effective administration of the Prepaid Health Care Act as it existed on September 2, 1974, the fee schedule amendment can be highlighted against past amendments to the Act. In short, the preempted amendments were at least related to the central ideas of the Act. The fee schedule amendment is not. The unpreempted amendments tended to enforce or clarify existing rights and duties. The fee schedule amendment creates new duties.

There have been a total of fourteen amendments to the Prepaid Health Care Act since its original enactment on June 12, 1974. The amendments were passed by the legislature between 1975 and 1994. Of the fourteen, two are deemed preempted.¹⁵

The Two Preempted Amendments

The two amendments deemed preempted by ERISA are the substance abuse benefits amendment and the union equivalency amendment. The former, the substance abuse benefits amendment, required prepaid health care plans to add substance abuse benefits to the benefits already specified under the original Act.¹⁶ It is deemed preempted by Congress.¹⁷

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15. There is a third amendment, which in a sense is preempted, but will not be part of the analysis in this study. Act 99, Session Laws of Hawaii 1994, was approved on June 8, 1994, but has not yet taken effect. It is scheduled to take effect upon the occurrence of an event that has not yet occurred. Specifically, the act is scheduled to take effect upon the effective date of any federal act permitting the amendment of the Hawaii Prepaid Health Care Act. If Act 99 ever takes effect, it will amend the Hawaii Prepaid Health Care Act by repealing the provision in the Hawaii Prepaid Health Care Act that repeals the Hawaii Prepaid Health Care Act upon the effective date of federal legislation relating to prepaid health care. Act 99 deals more with the relationship between conflicting federal and state laws, rather than with the relationship among the entities regulated under that particular state law.
 16. Act 25, Session Laws of Hawaii 1976, amended section 393-7, *Hawaii Revised Statutes*, on required health care benefits by amending subsection (c) to require that prepaid health care plans include substance abuse benefits. Under the Prepaid Health Care Act as it existed on September 2, 1974, section 393-7 had required health care plans to include hospital benefits, surgical benefits, medical benefits, diagnostic laboratory services, and maternity benefits. Act 210, Session Laws of Hawaii 1974, section -7.
 17. It was the intent of Congress that the 1983 ERISA exemption for the Hawaii Prepaid Health Care Act would not cover the state Legislature's 1976 substance abuse benefits amendment. In other words, Congress intended to maintain ERISA's preemption of the Legislature's amendment.

The U.S. Senate explained that "Because the exception is restricted to the Hawaiian Prepaid Health Care Act as in effect on January 1, 1977, provisions of that Act made effective after that date, relating to drug and alcohol abuse treatment will continue to be preempted by ERISA."

(Footnote continued on next page.)

The latter, the union equivalency amendment, required prepaid health care plans that were negotiated through collective bargaining to provide the union employees with protection at least equivalent to that provided under the Act.¹⁸ In contrast the original Act simply allowed employees to bargain collectively for different prepaid health care coverage.¹⁹ The amendment was deemed preempted in a federal district court.²⁰

Both amendments, though substantive, were at least closely related to the two basic principles of the Act, which are the minimum coverage requirement and the duty of employers to

Senate Report No. 97-646, Public Law No. 97-473, U.S.C.C.A.N. Vol. 4, 1982, 97th Congress 2d Session. The House of Representatives made no reference to substance abuse benefits in its conference report, but did change the trigger date to September 2, 1974. House Conference Report No. 97-984, Public Law No. 97-473, 1982, U.S.C.C.A.N. Vol. 4, 97th Congress 2d Session 1982. However, a Congressman confirmed that: “It should be noted that the provision of the Hawaii law which triggered the Standard Oil challenge remains preempted under the new exception.” Council of Hawaii Hotels, 595 F.Supp. at 455 n. 9, quoting Rep. Erlenborn from 128 Cong.Rec. H9,609-10 (daily ed. Dec. 13, 1982).

Furthermore, upon a review of the legislative history of the exemption the federal District Court for the District of Hawaii agreed that “It is clear that Congress intended to adhere to Standard Oil, preempting the Act’s drug and alcohol abuse treatment provisions.” Council of Hawaii Hotels, 595 F.Supp. at 455.

18. Act 199, Session Laws of Hawaii 1978, amended section 393-19, *Hawaii Revised Statutes*, on freedom of collective bargaining, by amending subsection (a) to require that prepaid health care plans negotiated through collective bargaining provide the employees with protection at least equivalent to that provided by the Prepaid Health Care Act.
19. Act 210, Session Laws of Hawaii 1974, section 1 (-19).
20. The federal District Court for the District of Hawaii held in Council of Hawaii Hotels that the 1978 amendment provided for more than the “effective administration” of the Hawaii Prepaid Health Care Act. Therefore, the provisions purporting to regulate certain collectively bargained health care plans could not be enforced under ERISA. Council of Hawaii Hotels, 594 F.Supp. at 452-453.

The court reviewed the history and language of the 1974 Hawaii Prepaid Health Care Act and determined that it was the intent of the state Legislature in 1974 to exempt collectively bargained agreements from coverage under the Act. Council of Hawaii Hotels, 594 F.Supp. at 453-454. The court also reviewed the history and language of the 1978 union equivalency amendment and determined that it was also the understanding of the state legislature in 1978 that collectively bargained health care plans were not covered by the Hawaii Prepaid Health Care Act, as originally enacted. *Id.*, at 454. Thus, to require collectively bargained plans to meet the statutory equivalency standard clearly amounted to a substantive change. *Id.*, at 454.

The court also reviewed the history of the 1983 ERISA exemption for the Hawaii Prepaid Health Care Act and determined that Congress intended the term “effective administration” to be construed strictly. Even Congress had been given to understand that the Hawaii Prepaid Health Care Act, as enacted in 1974, did not apply to collectively bargained health plans. Thus, in granting the ERISA exemption, Congress could not conceivably have intended the ERISA exemption to permit Hawaii to regulate collectively bargained health plans. Council of Hawaii Hotels, 594 F.Supp. at 455-456.

provide that coverage. The substance abuse amendment added a new required benefit to the minimum coverage requirements, thereby increasing the employer's duty of coverage. The union equivalency amendment applied the minimum coverage requirements to plans outside the scope of the Act, thereby imposing the duty of coverage to employers otherwise exempt from the Act.

In contrast the proposed fee schedule amendment is substantive but is not closely related to the two principles of the Act. The amendment requires persons to use two particular fee schedules that might not otherwise be used as the method of reimbursement for specified treatments. However, the duty to use the fee schedules is imposed on the health care contractor and the health care provider. Methods of reimbursement form no part of the employer's duty to cover the employees with health care coverage.

The Unpreempted Amendments

Lastly, there are eleven amendments to the Hawaii Prepaid Health Care Act enacted between 1975 and 1991 that have not been deemed preempted. They evidently provide for no more than the effective administration of the Act as it existed on September 2, 1974.

They can be divided into three groups. One group of amendments is merely technical and non-substantive. They incorporate name changes or gender-neutral terms.²¹ A second group of amendments is comprised of enforcement measures. They encourage compliance with existing requirements by penalizing noncompliance. New penalties are added to augment existing ones or are added where no penalties previously existed.²² A third group of amendments tends to facilitate the implementation and execution of existing law. In particular, they clarify

21. Act 339, Session Laws of Hawaii 1987, amended section 393-5, *Hawaii Revised Statutes*, to reflect the revised name of a state agency referred to in the text.

Act 217, Session Laws of Hawaii 1989, amended the same section 393-5 to replace a gender specific term with a gender neutral one.

22. Act 91, Session Laws of Hawaii 1977, added new section 393-24, *Hawaii Revised Statutes*, to make an employer liable for his employee's health care costs if those costs are incurred at a time when the employer has failed to provide the employee with prepaid health care coverage.

Act 190, Session Laws of Hawaii 1977, amended section 393-33, *Hawaii Revised Statutes*, by making it possible for an employer to be enjoined from doing business in the State for as long as the employer fails to provide his employees with coverage under a prepaid group health care plan.

Both Act 91 and Act 190 augment the existing penalty of a fine for non-compliance in section 393-33, *Hawaii Revised Statutes*.

Act 107, Session Laws of Hawaii 1991, added new section 393-34, *Hawaii Revised Statutes*, to specify a fine amount for the violation of any provision for which no penalty is otherwise provided.

the intent of existing provisions.²³ They remove unintended effects.²⁴ Or, they supplement the enforcement of existing rights.²⁵

In contrast, the fee schedule amendment is first of all not a technical, non-substantive amendment. It does not, for example, update the names of agencies or directors. Second, the fee schedule amendment is not an enforcement measure. It does not authorize fines or injunctions against the employer for not complying with a legal mandate. Rather, the fee schedule amendment creates new legal mandates, for health care plan contractors and health care providers. Third, the fee schedule amendment does not facilitate the implementation and execution of existing law. It does not clarify the intent of existing provisions. Rather, it creates new provisions, moving the original act in a new direction. The amendment also does not remove unintended effects. Rather, it creates effects that were not originally intended, because mandatory methods of reimbursement and price controls on providers were not encompassed under the original act. The fee schedule amendment also does not supplement the enforcement of existing rights. Rather, it potentially supplements the existing *policy* of holding down employees' medical costs by creating new *law*.

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23. Act 51, Session Laws of Hawaii 1975, amended section 393-6, *Hawaii Revised Statutes*, to promote consistency in the manner in which an employee chooses which of his employers is his principal employer.

Act 78, Session Laws of Hawaii 1976, amended the definition of "wage" in section 393-3, *Hawaii Revised Statutes*, to specify that the term also includes non-cash remuneration.

24. Act 81, Session Laws of Hawaii 1976, amended 393-21, *Hawaii Revised Statutes*, to authorize an employee to waive all of the required health care benefits if the employee has other coverage under a prepaid health care plan that provides benefits that meet the minimum standards.

Act 110, Session Laws of Hawaii 1978, amended section 393-5, *Hawaii Revised Statutes*, by excluding domestic and day care services as employment if the services are authorized by the state agency overseeing human services and the employer is a recipient of social service payments from that agency. This act exempts certain persons from being deemed employers obligated to provide their employees with coverage under a group prepaid health care plan. It was not the intent of the state human services agency to have those recipients treated as employers by the state labor department. Senate Standing Committee Report No. 314-78, on S.B. No. 2620-78, Senate Journal 1978.

25. Act 206, Session Laws of Hawaii 1976, amended section 393-13, *Hawaii Revised Statutes*, by authorizing an employer to make a deduction from a terminated employee's last salary or wage to recover the employer's prepayment of the employee's share of the cost of coverage.

Act 3, Session Laws of Hawaii 1978, added a new section 393-48, *Hawaii Revised Statutes*, to require the premium supplementation fund to pay prepaid health care benefits to employees of bankrupt or non-compliant employers as well as assist certain employers in making premium payments.

Timeline of Events Regarding the Prepaid Health Care Act

The table below lists in chronological order major events related to the Hawaii Prepaid Health Care Act and the Employee Retirement Income Security Act of 1974.

Table 2

PREPAID HEALTH CARE AND ERISA

Event	Date
The Hawaii Prepaid Health Care Act	6/12/74
ERISA	9/2/74
Substance abuse benefits amendment in Prepaid Health Care	7/1/76
<i>Standard Oil</i> suit initiated in federal court	12/7/76
<i>Standard Oil</i> federal district court decision	11/21/77
Union equivalency amendment in Prepaid Health Care	1/1/78
<i>Standard Oil</i> federal appellate court decision	10/15/80
ERISA exemption for the Prepaid Health Care Act	1/14/83
<i>Hawaii Hotels</i> federal district court decision	9/17/84

Conclusion Regarding the Exemption for the Hawaii Prepaid Health Care Act

Establishing fee schedules by directly amending the Hawaii Prepaid Health Care Act is legally impermissible under federal law.

Specifically, the federal Employee Retirement Income Security Act of 1974, as amended, preempts the establishment of fee schedules in the Hawaii Prepaid Health Care Act. The federal act otherwise preempts state laws such as the Hawaii Prepaid Health Care Act that relate to employee benefit plans. Although ERISA has a specific but limited exemption for the Hawaii Prepaid Health Care Act and some of its amendments, the fee schedule amendment does not fit the exemption.

ERISA exempts the Hawaii Prepaid Health Care Act as it existed on September 2, 1974. It also permits amendments that do no more than provide for the effective administration of the Act as in effect on that date. The fee schedule amendment is not that kind of amendment. It imposes duties upon prepaid health care plan contractors and health care providers. Specifically, it requires health care plan contractors to use two prescribed fee schedules in their reimbursement of providers. It also requires health care providers to charge not more than the fee schedule amounts and to accept payments under the fee schedules as payment in full.

There is an alternative approach to establishing fee schedules in the Hawaii Prepaid Health Care Act. The approach, as discussed in the next chapter, is to establish the fee schedules in the health insurance and related statutes.

Chapter 6

THE ALTERNATIVE APPROACH OF ESTABLISHING THE FEE SCHEDULE IN THE INSURANCE CODE AND RELATED STATUTES

Introduction

The conclusion in the previous chapter was that amending the Hawaii Prepaid Health Care Act to add fee schedules would be legally impermissible under ERISA. Such an amendment would provide for more than just the “effective administration” of the Act as it existed on September 2, 1974.

An alternative approach within the insurance systems is to establish a fee schedule in the health insurance and related statutes, with the same factors and assumptions as set forth in chapter three relating to fee schedules in the Prepaid Health Care Act. The relevant statutes are those covering group and blanket disability insurance under chapter 431, article 10A, part II; mutual benefit societies under chapter 432, article 1; and health maintenance organizations under chapter 432D. These statutes can be amended to make the two workers’ compensation fee schedules govern health care provider reimbursements under group policies.

The amendment could read as follows:

§[] **Medical fee schedule.** The charges for services received under each group health policy shall not exceed one hundred ten per cent of participating fees prescribed in the Medicare Resource Based Relative Value Scale System applicable to Hawaii (Medicare Fee Schedule) or Exhibit A at the end of chapter 12-15, Hawaii Administrative Rules, entitled “Workers’ Compensation Supplemental Medical Fee Schedule” (Exhibit A).

However, establishing “universal” fee schedules through amendments to these laws will not operate as efficiently as a direct amendment to the Hawaii Prepaid Health Care Act. The amendment will impact all group health insurance policies, both employer and non-employer group policies. The non-employer policies include policies for professional association groups, trade association groups, and credit union groups.¹ Furthermore, employer group policies are not identical with prepaid health care plans. Employer group policies may include policies offered under union negotiated employer plans and government employer plans that fall outside the scope of the Hawaii Prepaid Health Care Act. Also, employer group policies will not include prepaid health care plans that are not insurance policies, such as those that provide medical services directly to the employee.

1. See generally section 431:10A-201(4), *Hawaii Revised Statutes*, on group disability insurance.

In addition to the inefficiency of the amendment, ERISA will still be a legal obstacle. The ERISA analysis and conclusions are set out in brief as follows:

- (1) Does the fee schedule amendment “relate to” an employee benefit plan?

Yes, it does. A law “relates to” an employee benefit plan if it either has a “reference to” or a “connection with” an employee benefit plan.

Here, the fee schedule amendment has a “reference to” employee benefit plans because group health insurance policies are defined to include employee group policies, and the amendment directly operates on employee benefit plans. It also has “connection with” employee benefit plans, because the fee schedule is an administrative burden on employee benefit plans. The amendment directly operates on employee benefit plans and is an administrative burden on employee benefit plans because under the Hawaii Prepaid Health Care Act employers are required to cover their employees under a prepaid health care plan.

- (2) If the fee schedule amendment “relates to” an employee benefit plan, is there an exemption that may apply?

Yes, there is an exemption for state laws that “regulate insurance”.

- (3) If there is an exemption that applies, does the exemption save the fee schedule amendment from preemption?

No, because the fee schedule amendment does not fit the exemption.

A state law “regulates insurance” if it meets both the “common- sense view” of insurance regulation and the McCarran-Ferguson criteria for the “business of insurance”.

The fee schedule amendment appears to fail both tests.

Under the “common-sense view” a law regulates insurance if the law is “specifically directed toward the insurance industry”.

The fee schedule amendment is not specifically directed toward the insurance industry. It is directed as well at the health care industry. It also does not necessarily benefit insureds.

The McCarran-Ferguson criteria for whether a particular practice constitutes the “business of insurance” are:

- (i) whether the practice has the effect of transferring or spreading a policyholder’s risk;

- (ii) whether the practice is an integral part of the policy relationship between the insurer and the insured; and
- (iii) whether the practice is limited to entities within the insurance industry.

The fee schedule amendment fails two of the three criteria. It is not an integral part of the policy relationship between the insurer and the insured. It is also not limited to entities within the insurance industry.

Thus, it is not legally permissible under ERISA to establish a fee schedule in the health insurance statutes.

The tests for determining whether a state law “relates to” an employee benefit plan so as to be preempted, and whether such a law “regulates insurance” so as to be saved from preemption, have been developed in the opinions of the United States Supreme Court. The key Supreme Court opinion with regard to the savings test is *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). The federal Court of Appeals for the Ninth Circuit recently applied the Supreme Court’s preemption and savings tests to a Washington alternative provider statute, which requires insurers to give insureds access to all categories of health care provider. The Ninth Circuit’s style of analysis in *Washington Physicians Service Ass’n v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), cert. denied 525 U.S. 1141 (1999), is relevant because the Ninth Circuit includes Hawaii.²

The ERISA analysis and conclusions are set out again in greater detail below.

Does the Fee Schedule Amendment “Relate to” an Employee Benefit Plan?

As set out in a previous chapter, the ERISA preemption language, at 29 U.S.C. section 1144(a) reads as follows:

- (a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

In plain words, the ERISA provisions on the protection of employee benefit rights and on plan termination insurance will preempt state laws that “relate to” employee group health insurance plans.

2. 28 U.S.C. section 41.

“Relates to”

ERISA preempts a state law if the state law “relates to” an employee benefit plan. In a 1983 opinion the United States Supreme Court declared that:

A law “relates to” an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan.³

The Supreme Court said that Congress used the words “relate to” in their broad sense. The preemption provision cannot be read to preempt only state laws that are specifically designed to affect employee benefit plans. Furthermore, the Supreme Court said that the preemption provision cannot be read to pre-empt only state laws that deal with the subject matters covered by ERISA--reporting, disclosure, fiduciary responsibility, and the like.⁴

On the other hand, the Supreme Court has also stated in more recent opinions that the Court addresses preemption matters starting from the presumption that Congress does not intend to supplant state law.⁵

“Reference to”

In a 1997 opinion, the Supreme Court identified two types of state laws that make “reference to” an employee benefit plan.⁶ One type is the state law that acts immediately and exclusively upon an employee benefit plan. An example provided by the Supreme Court of a state law that acts immediately and exclusively upon an employee benefit plan is the Georgia anti-garnishment statute that says:

Funds or benefits of a pension, retirement, or employee benefit plan or program subject to the provisions of the federal Employee Retirement Income Security Act of 1974, as amended, shall not be subject to the process of garnishment . . .⁷

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3. Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97 (1983), on remand to 725 F.2d 146 (2nd Cir. 1983), and on remand to 725 F.2d 148 (2nd Cir. 1983), and on remand to 725 F.2d 149 (2nd Cir. 1983).
 4. Shaw, 463 U.S. at 98.
 5. Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 741 (1985); New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 654 (1995), on remand to 63 F.3d 89 (2nd Cir. 1995).
 6. California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc., 519 U.S. 316, 325 (1997), on remand to 190 F.3d 1034 (9th Cir. 1999).
 7. California Div. of Labor Standards Enforcement, 519 U.S. at 325, citing Mackey v. Lanier Collection Agency and Serv., 486 U.S. 825, 829 n.2 (1988), quoting Ga. Code Ann. 18-4-22.1 (1982).

The other type of state law that makes “reference to” an employee benefit plan is where the existence of employee benefit plans is essential to the operation of the state law. In other words, the state law that cannot operate unless an employee benefit plan exists. An example provided by the Supreme Court of a state law for which the existence of employee benefit plans is essential to the law’s operation is the District of Columbia workers’ compensation statute that says:

Any employer who provides health insurance coverage for an employee shall provide health insurance coverage equivalent to the existing health insurance coverage of the employee while the employee receives or is eligible to receive workers’ compensation benefits under this chapter.⁸

The Supreme Court noted that the workers’ compensation statute “specifically refers to welfare benefit plans regulated by ERISA and on that basis alone is pre-empted.”⁹

In the Ninth Circuit, the Court of Appeals noted that in the Supreme Court and lower federal court cases that found a “reference” to ERISA plans, “the state laws in these other cases all included ERISA plans in the definition of ‘health plan’ or otherwise expressly referred to ERISA plans.”¹⁰ Furthermore, the Court of Appeals said that a law does not have a “reference to” ERISA plans unless the law operates directly on them.¹¹

The Court of Appeals pointed out that a law that directly operates on a benefit plan offered by the employer is different from a law that directly operates on a health plan offered by a carrier. The alternative provider statute at issue in *Washington Physicians* directly operated on a health plan, and operated only indirectly on a benefit plan. It operated indirectly on a benefit plan whenever the benefit plan chose to purchase health insurance on the market rather than provide the insurance as a self-insurer or not provide insurance at all. If the benefit plan were self-insured it would be exempt from the alternative provider statute. Moreover, a benefit plan in the State of Washington is under no state statutory requirement to provide health insurance at all.¹²

To reiterate, the Ninth Circuit finds that a law has a “reference to” ERISA plans if the law expressly refers to ERISA plans or includes ERISA plans in the definition of a health plan (a health insurance policy), and directly operates on a benefit plan.

8. California Div. of Labor Standards Enforcement, 519 U.S. at 325, citing *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 128 (1992), quoting D.C. Code Ann. section 36-307(a-1)(1)(Supp. 1992).

9. *Greater Washington Board of Trade*, 506 U.S. at 130.

10. *Washington Physicians*, 147 F.3d at 1044.

11. *Id.*

12. *Washington Physicians*, 147 F.3d at 1043.

Here, the hypothetical universal fee schedule amendment has been drafted to avoid obvious express references to an ERISA plan. The amendment does not apply exclusively to employee benefit plans as in the Georgia anti-garnishment statute. It also does not expressly refer to employer health insurance coverage as in the District of Columbia workers' compensation statute. The amendment simply applies to all group health insurance policies.

However, those policies include employee group policies, by definition. In the insurance code, group health insurance, technically known as group disability insurance¹³, is defined to include employee groups.¹⁴ In the health maintenance organization statutes, enrollees covered under a health maintenance organization include subscribers, who are individuals whose employment or other status is the basis for eligibility for enrollment.¹⁵ In the mutual benefit society statutes, employer group health policies are among the group service plan contracts regulated.¹⁶ Moreover, employee group policies appear to be ERISA plans, also by definition.¹⁷

The fee schedule amendment is thus analogous to the cases cited by the Ninth Circuit in which the state laws included ERISA plans in the definition of a health plan or health insurance policy. One example cited was the Pennsylvania anti-subrogation statute at issue in a 1990 United States Supreme Court opinion.¹⁸ The statute incorporated ERISA plans in a rather oblique manner as follows:

In actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to...benefits in lieu thereof paid or payable under section 1719. . . .¹⁹

That section 1719 referred to any "program, group contract or other arrangement for payment of benefits", which in turn "includes, but is not limited to, benefits payable by a hospital plan corporation or a professional health service corporation . . .".²⁰ In its opinion, then, the United

13. Sections 431:1-205, 10A-201(4), *Hawaii Revised Statutes*.

14. Sections 431:10A-201(4), 10D-202, *Hawaii Revised Statutes*.

15. Section 432D-1, *Hawaii Revised Statutes*.

16. *See, e.g.*, section 432:1-604.5, *Hawaii Revised Statutes*.

17. 29 U.S.C. section 1002(1). Employee welfare benefit plans include plans that provide participants, through the purchase of insurance, with medical, surgical, or hospital care or benefits, or benefits in the event of sickness and accident.

18. *Washington Physicians*, 147 F.3d at 1044, citing *FMC Corp. Holliday*, 498 U.S. 52, 59 (1990), appeal after remand, 932 F.2d 959 (3rd Cir. 1991).

19. *FMC Corp.*, 498 U.S. at 55, note 1, quoting section 1720 of the Pennsylvania Motor Vehicle Financial Responsibility Law.

20. *FMC Corp.*, 498 U.S. at 55, note 2, quoting section 1719 of the Pennsylvania Motor Vehicle Financial Responsibility Law.

States Supreme Court had evidently found that the antisubrogation statute made “reference to” ERISA benefit plans in the statutory phrase “includes, but is not limited to”.²¹

Another example cited by the Ninth Circuit was the Texas “any willing provider” statute at issue in a Fifth Circuit Court of Appeals case.²² The statute prohibited a “health insurance policy” from denying a willing provider the right to participate as a contract provider under the policy. In that case, the Fifth Circuit concluded that the statute relates to ERISA benefit plans because “Garden variety employer health insurance plans, which are regulated by the Texas statute, are ‘employee benefit plans’ under ERISA”²³

Thus, although the fee schedule amendment does not expressly refer to employee benefit plans, it includes ERISA plans in the definition of a group health insurance policy. The amendment also directly operates on employee benefit plans. As explained in the next section below on the amendment’s “connection with” ERISA plans, administrative burdens, such as the mandatory use of a particular fee schedule, that are placed on group health insurance policies are automatically placed as well on prepaid health care plans. Accordingly, the fee schedule amendment has a “reference to” employee benefit plans, and therefore “relates” to employee benefit plans so as to be subject to ERISA preemption.

As discussed below, the other possible way that the amendment can “relate to” an employee benefit plan is if the amendment has a “connection with” an employee benefit plan.

“Connection with”

In a 1995 opinion the United States Supreme Court said that a state law has a “connection with” an ERISA plan if the state law mandates employee benefit structures or their administration.²⁴ Such a statute impermissibly “relates to” an employee benefit plan, because one of the Congressional objectives of ERISA was to “minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government”.²⁵ Preemption of such a law is warranted in order to “avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans.”²⁶

21. FMC Corp., 498 U.S. at 59.

22. Washington Physicians, 147 F.3d at 1044, citing Texas Pharmacy Ass’n v. Prudential Ins. Co., 105 F.3d 1035, 1037 (5th Cir.), cert. denied 522 U.S. 820 (1997).

23. Texas Pharmacy Ass’n, 105 F.3d at 1037 quoting Tex. Ins. Code Ann. at 21.52B, section 2.

24. New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656, 658 (1995), on remand to 63 F.3d 89 (2nd Cir. 1995).

25. New York State Conference of Blue Cross & Blue Shield Plans, 514 U.S. at 656, quoting Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990), on remand to 807 S.W.2d 577 (Texas 1991).

26. New York State Conference of Blue Cross & Blue Shield Plans, 514 U.S. at 657.

The Ninth Circuit Court of Appeals, too, reiterated in 1998 that a state law has a “connection with” ERISA plans if it affects the structure of ERISA plans, imposes an administrative burden on them, and controls administrative choices about with whom to contract.²⁷

Here, the hypothetical universal fee schedule amendment appears to impose an administrative burden on ERISA plans. First, it is an administrative burden on group health insurance policies because it dictates the method of reimbursement under the policy. Specifically, it requires the use of one particular method of reimbursement to the exclusion of any other method of reimbursement. Furthermore, it requires the use of two particular fee schedules to the exclusion of any other fee schedules.

Second, and more importantly, it is a burden on ERISA plans because any requirement imposed on group health insurance policies is automatically imposed on some prepaid health care plans. Under the Hawaii Prepaid Health Care Act, employers are required to cover their employees under a prepaid health care plan, which is an ERISA plan.²⁸ The prepaid health care plan must provide employees with group health insurance coverage, unless the plan provides medical services directly.²⁹ Accordingly, a mandate imposed on group health insurance policies to use specified fee schedules for reimbursements becomes as well a mandate imposed on some prepaid health care plans to use those fee schedules.

Since a law imposed on a group health insurance policy becomes in effect a law imposed as well on a prepaid health care plan, the distinction in Hawaii between the ERISA plan and the group health insurance policy is blurred. Accordingly, the facts relevant to the fee schedule amendment are distinguishable from those relevant to the alternative provider statute at issue in *Washington Physicians*.

In *Washington Physicians*, the distinction between the ERISA plan and the health carrier was the decisive factor in the court’s conclusion that the Washington statute bore no “connection with” an ERISA plan. The alternative provider statute was construed to operate only on health carriers that were distinct from ERISA plans. The statute imposed no requirements on the employers to provide any particular welfare benefit to employees, and it did not impose any burden on the plan in its administering of benefits that the plan chose to provide. The burdens fell on the health carrier.³⁰ In Washington, evidently, health carriers must allow insureds access to alternative providers, but employers are not required to provide health insurance to their employees.

27. *Washington Physicians*, 147 F.3d at 1044.

28. *See generally* *Standard Oil Co. of California v. Agsalud*, 633 F.2d 760 (9th Cir. 1980), affirmed 454 U.S. 801 (1981).

29. Act 210, Session Laws of Hawaii 1974, section 1 (-12).

30. *Washington Physicians*, 147 F.3d at 1044.

Thus, the hypothetical universal fee schedule amendment has a “connection with” ERISA plans. Accordingly, since the fee schedule amendment has a “connection with” an ERISA plan, the amendment “relates to” an employee benefit plan. The amendment is therefore preempted unless saved by an exemption. The next question then is whether an exemption exists that may apply to save the fee schedule amendment from preemption.

Is There an Exemption that May Apply?

There is an exemption that applies to state laws that “regulate insurance”. The insurance savings exemption is found at 29 U.S.C. section 1144(b)(2)(A). It reads as follows:

Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

In plain words, there are ERISA provisions relating to the protection of employee benefit rights. They deal with reporting and disclosure, participation and vesting, funding, fiduciary responsibility, and administration and enforcement. These ERISA provisions do not preempt a state law that regulates insurance, banking, or securities. However, the “deemer” clause does not permit employee benefit plans themselves to be “deemed” insurance companies, banks, trust companies, or investment companies so as to fall under the exemption for laws that regulate insurance, banking, or securities.³¹

In other words, the insurance savings clause is composed of two parts. First, ERISA saves from preemption a state law that “relates to” an employee benefit plan, if the law “regulates insurance”. Second, under the “deemer” clause, ERISA nonetheless preempts a state

31. The technical terms and references in 29 U.S.C. section 1144(b)(2)(A) are explained as follows:

- (1) “this subchapter” is subchapter 1, which deals with the protection of employee benefit rights; and
- (2) “subparagraph (B)” specifies that a private sector employee benefit plan shall not be deemed to be an insurance company. It is the so-called “deemer” clause and reads as follows:

“(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.”

law that “relates to” an employee benefit plan but “regulates insurance”, if the law “deems” employee benefit plans to be insurers.³²

The “deemer” clause is not an issue here with regard to the hypothetical universal fee schedule amendment, but it may become a factor that affects the types of prepaid health care plans that the fee schedule amendment may regulate. The “deemer” clause distinguishes self-funded ERISA plans from insured ERISA plans. The Supreme Court said that the insurance savings clause allows states to regulate insured ERISA plans but does not allow states to regulate self-funded ERISA plans or uninsured ERISA plans.³³ “Insured plans” are plans that purchase insurance for their participants.³⁴

The “deemer” clause may be a factor with regard to the application of the fee schedule amendment to prepaid health care plans because the Hawaii Prepaid Health Care Act establishes two types of prepaid health care plans, one uninsured and the other insured. Under the uninsured plan the medical organization provides health care directly to the employee. Under the insured plan an insurer reimburses the expenses of health care.³⁵ If the fee schedule amendment is a law that “regulates insurance” the amendment will apply to plans under which an insurer reimburses the expenses of health care. It will be preempted from applying to plans under which the medical organization provides direct health care.

The single issue to be considered here concerns the first part of the insurance savings clause, specifically, whether the fee schedule amendment is a law that “regulates insurance”.

Does the Exemption Save the Hypothetical Universal Fee Schedule Amendment from Preemption?

In *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), the United States Supreme Court formulated a two-part insurance savings test to determine whether a state law “regulates insurance” within the meaning of 29 U.S.C. section 1144(b)(2)(A). The first part of the insurance savings test is that the state law “regulates insurance” if the state law fits a “common-sense view” of the phrase “regulates insurance”.³⁶ The second part of the insurance savings test is that the state law “regulates insurance” if the state law regulates practices that under the McCarran-Ferguson Act are the “business of insurance”.³⁷

32. See, *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990), appeal after remand 932 F.2d 959 (3rd Cir. 1991).

33. See, *FMC Corp.*, 498 U.S. at 61-63.

34. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 733 (1985).

35. Act 210, Session Laws of Hawaii 1974, section 1 (-3(7)).

36. *Metropolitan Life Ins. Co.*, 471 U.S. at 740; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48, 50 (1987), on remand to 821 F.2d 277 (5th Cir. 1987).

37. *Metropolitan Life Ins. Co.*, 471 U.S. at 742-743; *Pilot Life Ins. Co.*, 481 U.S. at 48-49.

The United States Supreme Court developed the test in *Metropolitan Life* to examine a Massachusetts mandated benefits statute, which required health insurance policies and employee health and welfare funds that provide hospital expense and surgical expense benefits to also provide certain minimum mental health care benefits.³⁸

The Ninth Circuit Court of Appeals in *Washington Physicians* applied the test in 1998 to an alternative provider statute that requires insurers to give insureds access to all categories of health care provider.³⁹ The Ninth Circuit requires a state law to pass both parts of the insurance savings test in order to be saved from preemption.⁴⁰

The federal circuits other than the Ninth have applied the insurance savings test to “any willing provider” statutes, which impose restrictions on an insurer’s ability to form preferred provider organizations with health care providers. These statutes are somewhat analogous to a fee schedule amendment because they affect the charges payable to health care providers. Of these circuits, the Fifth⁴¹ and Eleventh⁴² also construe the two-part insurance savings test to be a conjunctive test. A state law must pass both parts of the test in order to be deemed a law that “regulates insurance” within the meaning of the savings clause.

As background, a preferred provider organization is established through an insurer’s contracts with health care providers for reduced charges. Insureds are encouraged to use these providers. If an insured uses a provider outside of the preferred provider organization, the insured generally must pay a higher fee for the service rendered and be reimbursed at a lower

38. Specifically, the Massachusetts mandated benefits statute at issue in *Metropolitan Life* stated that:

“Any blanket or general policy of insurance...or any policy of accident and sickness insurance...or any employees’ health and welfare fund which provides hospital expense and surgical expense benefits...shall, provide benefits for expense...arising from mental or nervous conditions...”

Metropolitan Life, 471 U.S. at 730 note 11, quoting Massachusetts Gen. Laws Ann., ch. 175, section 47B (West Supp. 1985).

39. *Washington Physicians*, 147 F.3d at 1042.

40. *Id.* at 1045.

41. *CIGNA Healthplan v. State of La.*, 82 F.3d 642, 650 (5th Cir. 1996), cert. denied 519 U.S. 964 (1996).

42. *Blue Cross and Blue Shield of Alabama v. Nielsen*, 917 F.Supp. 1532, 1538 (N.D. Ala. 1996), aff’d in part, vacated in part, remanded by 142 F.3d 1375 (11th Cir. 1998). The federal court of appeals for the Eleventh Circuit certified questions of state law to the Alabama Supreme Court. These questions dealt with whether the provider statutes applied to Blue Cross. On return to the federal court from the state court, the Court of Appeals held that the Alabama Supreme Court’s holding mooted the ERISA preemption issue, thus warranting vacatur of that portion of the District Court’s judgment pertaining to ERISA preemption. In other words, the federal district court’s ERISA discussion is effectively dicta.

rate.⁴³ The “any willing provider” statutes are aimed at prohibiting insurers that use preferred provider organizations from denying any provider who is willing to meet the terms and conditions of the preferred provider contract the right to become a preferred provider.⁴⁴ These statutes are a regulation of the insurers, since they prohibit insurers from unfairly discriminating among providers. They are not a regulation of providers. No requirements are imposed on providers. Rather, the statutes bestow a benefit on them. Removal of discriminatory barriers imposed by insurers expands their market opportunities.

Common-Sense View

In *Metropolitan Life* and *Pilot Life*, the United States Supreme Court provided two different formulations of the “common-sense view” of a law that “regulates insurance”.

In *Pilot Life*, the Supreme Court said that in order to regulate insurance, a “law must not just have an impact on the insurance industry, but must be specifically directed toward that industry.”⁴⁵ The *Pilot Life* formulation was used in cases from the First,⁴⁶ Sixth,⁴⁷ Ninth,⁴⁸ and Eleventh⁴⁹ Circuits.

In *Metropolitan Life*, on the other hand, the Supreme Court said that laws that regulate “the substantive content of insurance contracts” are laws that regulate insurance.⁵⁰ The *Metropolitan Life* formulation was used in cases from the Fourth⁵¹ and Fifth Circuits.⁵²

Under either formulation the legal analyses are basically the same. The common sense view appears to be evolving into a two-part test shaped by the McCarran-Ferguson criteria.⁵³

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43. See, e.g., *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500, 501 (4th Cir. 1993), cert. denied 510 U.S. 1003 (1993).
 44. See, e.g., *CIGNA Healthplan*, 82 F.3d at 645; *Stuart Circle Hosp. Corp.*, 995 F.2d at 501.
 45. *Pilot Life Ins. Co.*, 481 U.S. at 50.
 46. *American Drug Stores v. Harvard Pilgrim Health*, 973 F. Supp. 60, 69-70 (D. Mass. 1997).
 47. *Community Health Partners v. Commonwealth of Ky.*, 14 F.Supp.2d 991, 1001 (W.D.Ky. 1998), affirmed __ F.3d __, 2000 WL 1359621 (6th Cir. 2000).
 48. *Washington Physicians*, 147 F.3d at 1045.
 49. *Blue Cross and Blue Shield of Alabama*, 917 F.Supp. at 1538.
 50. *Metropolitan Life*, 471 U.S. at 742 note 18.
 51. *Stuart Circle Hospital Corp.*, 995 F.2d at 502.
 52. *Texas Pharmacy v. Prudential Ins. Co. of America*, 907 F.Supp. 1019, 1025 (W.D. Tex. 1995), affirmed as modified in *Texas Pharmacy Ass’n v. Prudential Ins. Co.*, 105 F.3d 1035, 1040 (5th Cir. 1997), cert. denied 522 U.S. 820 (1997).
 53. See, e.g., *Washington Physicians*, 147 F.3d at 1047 regarding the analysis under the McCarran-Ferguson test. The common sense view of insurance regulation incorporates the first two criteria. The “reference to” analysis under the “relates to” issue incorporates the third criterion.

The first part is whether the state law regulates only insurers. The second part is whether the state law protects or primarily benefits the insureds. For the Ninth Circuit in particular, the Court of Appeals looked at whether the law confers a benefit on the insured in the sense of affecting the risk the insured bears.⁵⁴ Also in the Ninth Circuit, it appears that a law must pass both parts of the test to meet the common sense view of insurance regulation.⁵⁵

For the first issue of whether the state law regulates insurers, the courts have had to determine whether the state law regulates only insurers or whether it regulates payors that are not insurers. Specifically, courts have addressed the issue of whether insurer-like entities such as health maintenance organizations are insurers or non-insurers.⁵⁶ They have also had to address the issue of whether a statute reaches beyond insurers to regulate third party payors such as employee benefit plans, including self-funded plans and other plans not financed with insurance contracts.⁵⁷

For the second issue of whether the state law protects or benefits insureds different issues were initially asked. The *Pilot Life* jurisdictions initially asked whether the state law focuses on the regulation of the insurer and the insured, on the one hand, or whether it focuses on the regulation of the insurer and the health care provider. The *Metropolitan Life* jurisdictions initially asked whether the state law regulates the terms of the insurance policy between the insurer and the insured.

In the cases using the *Pilot Life* formulation, the courts concluded that the statutes regulated the insurer and the insured because the statutes benefited insureds by expanding the range of treatments that insurers must cover⁵⁸ or by widening the circle of providers that may provide benefits to the insureds.⁵⁹

In the cases using the *Metropolitan Life* formulation, the courts concluded that the statutes regulated the substantive content of insurance policies because the statutes benefited insureds by protecting the insured's choice of providers.⁶⁰

54. Washington Physicians, 147 F.3d at 1046.

55. See, e.g., Washington Physicians, 147 F.3d at 1046. A regulation of insurance regulates the correct entities and regulates the relationship between the carrier and the insured.

56. Washington Physicians, 147 F.3d at 1045-1046; American Drug, 973 F.Supp. at 70; Community Health Partners, 14 F.Supp.2d at 1002.

57. Blue Cross and Blue Shield of Alabama, 917 F.Supp. at 1539 regarding the Dental Act and the Pharmacy Act; Texas Pharmacy, 907 F.Supp. at 1025.

58. Washington Physicians, 147 F.3d at 1046.

59. American Drug, 973 F.Supp. at 70; Community Health Partners, 14 F.Supp.2d at 1002.

60. Texas Pharmacy, 105 F.3d at 1040, on the state's prior statute; Stuart Circle, 995 F.2d at 503.

As Applied to the Proposed Hypothetical Universal Fee Schedule

The Hypothetical Universal Fee Schedule Reaches Beyond Insurers. Under the *Pilot Life* formulation, the Ninth Circuit asks whether a state law is specifically directed at the insurance industry. The first component of that issue is whether the state law regulates only insurers.

Granted, the amendment regulates insurers because it requires the insurer to use a particular method of reimbursement to the exclusion of other methods of reimbursement and other fee schedules apart from the workers' compensation fee schedules.

However, the issue is whether the amendment also regulates entities other than insurers. The any willing provider statutes from the other federal circuits triggered merely the issue of whether the statutes reach payors who are not insurers. The fee schedule amendment in contrast triggers the issue of whether the amendment reaches payees as well as payors. The answer is that it does. The amendment reaches payees who are the health care providers. The amendment prohibits them from charging more than the fee schedule amounts. Furthermore, the amendment requires them to accept payment under the fee schedules as payment in full. Providers may not charge the insured for the difference between their desired charge and the payment provided under the schedules. Accordingly, the fee schedule amendment acts as a price control on the providers' charges.

Thus, the fee schedule amendment is not specifically directed solely toward the insurance industry. It also regulates the health care provider.

The Hypothetical Universal Fee Schedule Does Not Necessarily Benefit Insureds. After asking whether the state law regulates only insurers, the next question asked under the *Pilot Life* formulation is whether the relationship regulated by the state law is that between the insurer and the insured or that between the insurer and the health care provider. The determinative factor is whether the law protects insureds or primarily benefits insureds. As stated earlier, in the Ninth Circuit particular attention is paid to whether the law confers a benefit on the insured in the sense of affecting the risk the insured bears.⁶¹

Here, the relationship affected by the establishment of a fee schedule appears to be that between the insurer and the health care provider, not that between the insurer and the insured. A fee schedule is a method of reimbursement used by insurers to reimburse health care providers for services rendered to their insureds. The fee schedule sets both the highest amounts that a provider may charge and the highest amounts that the insurer owes the provider. Under health insurance policies, the bulk of the fee schedule amount is paid by the insurer. The remainder is paid by the insured as a co-payment. The fee schedule, however, does not set the maximum levels of the insured's co-payments.

61. *Washington Physicians*, 147 F.3d at 1046.

In any case, the determinative factor is whether the fee schedule amendment confers a benefit on the insured in the sense of affecting the risk the insured bears. For the reasons given below in the discussion of the first of the McCarran-Ferguson criteria, the fee schedule amendment appears to affect the risk the insured bears. It affects risk-spreading because it impacts the cost of treatment.

However, it is nonetheless difficult to see how the fee schedule amendment confers a benefit on the insured in the same sense that the other types of statutes conferred benefits on the insureds. Those other statutes addressed the issue of coverage, not the costs of the coverage. Moreover, the benefits conferred on insureds under those statutes were apparent from just the text of the statutes. The statutes expanded coverage under the policy beyond what had been required prior to the enactment of the statutes. The mandated benefits statute at issue in *Metropolitan Life* expanded the types of treatments covered under a policy. The alternative provider statute at issue in *Washington Physicians* expanded the insureds' access to more classes of health care providers. The any willing provider statutes at issue in the other federal circuits expanded the insureds' access to a greater number of providers within any given class of providers.

Inevitably, the result of expanded coverage under those statutes was higher costs of coverage, specifically, an increased level of premiums. However, the possibility that a higher level of premiums might negate benefits conferred under the statutes was not discussed in those opinions. The higher level of premiums was presumably irrelevant.

Here, the fee schedule amendment requires insurers to use a particular method of reimbursement in reimbursing providers. The amendment does not expand the insureds' coverage under the policy, but it may have some impact on the insureds' cost of coverage, specifically, the insureds' co-payments under the fee schedule or the insureds' premiums for coverage. The amendment therefore offers a different perspective on the benefiting of the insureds. If it benefits them, the amendment perhaps benefits the insureds through a reduction or containment of either the insureds' co-payments under the fee schedule or the insureds' resulting premiums under the policy. Presumably, the higher the fee schedule, the higher the insureds' co-payments or resulting premiums. The lower the fee schedule, the lower the insureds' co-payments or resulting premiums.

At the same time, the proposed fee schedule should not be set so low as to negatively impact the providers' services. Quality of care and access to care should remain unaffected. Otherwise, a fee schedule set too low will impose a detriment on insureds.

In other words, studies will need to be performed in order to determine whether the fee schedule amendment confers benefits on insureds. Whether benefits are conferred will not be evident from the mere text of the amendment. Also, since the Medicare fee schedule is periodically updated, the studies may need to be periodically updated as well.

Thus, it cannot be concluded with any demonstrable certainty that the fee schedule amendment confers a benefit on insureds.

Conclusion Regarding the Common-Sense View

The fee schedule amendment fails the first part of the insurance savings test of laws that “regulate insurance”. It fails to meet the common-sense view of insurance regulation. First, the fee schedule amendment is not specifically directed at the insurance industry. It also regulates health care providers. Second, the fee schedule amendment does not necessarily confer a benefit on insureds. There is no certainty from the text of the amendment itself that the fee schedules will minimize charges, and accordingly, premiums, and do so without adversely impacting provider services involving as the quality of provider care or access to provider care.

Since a state law must pass both parts of the insurance savings test, and the fee schedule amendment fails the first part, the fee schedule amendment therefore cannot be deemed a state law that “regulates insurance” within the meaning of the insurance savings exemption. Accordingly, ERISA can preempt the fee schedule amendment on the basis on the common-sense test alone.

In the event that the Bureau’s analysis under the common sense test is erroneous, the fee schedule amendment is also analyzed under the second part of the insurance savings test. The analysis under the McCarran-Ferguson criteria for the “business of insurance” is presented below.

The McCarran-Ferguson Criteria for the “Business of Insurance”

For the second part of the insurance savings analysis in identifying a state law that “regulates insurance”, the United States Supreme Court applied the McCarran-Ferguson criteria for identifying a practice that is the “business of insurance”.

The McCarran-Ferguson Act is a federal law that exempts the “business of insurance” from federal antitrust laws such as the Sherman Act and the Clayton Act.⁶² Furthermore, in two separate antitrust opinions the United States Supreme Court developed three criteria in order to determine whether a particular practice is part of the “business of insurance” so as to be exempt

62. The McCarran-Ferguson Act leaves the “business of insurance” to state regulation, 15 U.S.C. section 1012(a), and bars federal statutes from preempting state statutes that regulate the “business of insurance”, 15 U.S.C. section 1012(b). There are two exceptions. The first is that a federal statute will preempt a state statute if the federal statute specifically relates to the “business of insurance”. The second is that the Sherman Act and the Clayton Act will apply to the “business of insurance” if state law does not regulate such business, 15 U.S.C. section 1012(b).

from those antitrust laws.⁶³ The Supreme Court noted that none of the criteria is necessarily determinative in itself.⁶⁴ The three criteria are as follows:

- (1) Whether the practice has the effect of transferring or spreading a policyholder's risk;
- (2) Whether the practice is an integral part of the policy relationship between the insurer and the insured; and
- (3) Whether the practice is limited to entities within the insurance industry.⁶⁵

The United States Supreme Court subsequently applied the McCarran-Ferguson criteria to the Massachusetts mandated benefits statute at issue in *Metropolitan Life*, an ERISA case, for assistance in determining whether the Massachusetts statute “regulates insurance”.⁶⁶ In other words, the Court felt that a state law “regulates insurance” if it regulates practices that are part of the “business of insurance”. The Court’s rationale for applying the McCarran-Ferguson criteria was that regulation regarding the substantive terms of the insurance contracts falls squarely within the savings clause as laws which “regulate insurance.”⁶⁷

The Massachusetts mandated benefits statute in *Metropolitan Life* happened to meet all three criteria so as to be deemed a law that regulates the “business of insurance”.⁶⁸ However, the Supreme Court has not expressly stated that it is necessary for a state law to meet all three criteria in order to be deemed a law that regulates the “business of insurance”. The Court has indicated that meeting only the second of the three criteria is insufficient. In *Pilot Life*, the Supreme Court said that the McCarran-Ferguson criteria did not support the assertion that the Mississippi common law of bad faith “regulates insurance” because the common law of bad faith at most met the policy relationship criterion, but did not meet the risk-spreading or intra-industry criteria.⁶⁹ Furthermore, the Court has not indicated whether any one criterion is more important or less important than the other two.

The Ninth Circuit Court of Appeals has declared that for the Ninth Circuit, which includes Hawaii, the McCarran-Ferguson factors are simply relevant considerations or guideposts, not separate essential elements of a three-part test that must each be satisfied for a

63. The first is *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211- 230 (1979), rehearing denied 441 U.S. 917 (1979), appeal after remand 737 F.2d 1433 (5th Cir. 1984), cert. denied 469 U.S. 1160 (1985). The second is *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982).

64. *Pireno*, 458 U.S. at 129.

65. *Id.*

66. *Metropolitan Life Ins. Co.*, 471 U.S. at 742-743.

67. *Id.*

68. *Id.*

69. *Pilot Life*, 481 U.S. at 50-51.

law to escape preemption.⁷⁰ In other words, it is not necessary for a law to satisfy all three of the criteria in order to meet the McCarran-Ferguson half of the insurance savings analysis.⁷¹ Thus, such an interpretation tends to increase the possibility that a state law will meet the McCarran-Ferguson criteria. However, the failure to meet two of the three criteria, as in *Pilot Life*, suggests an overall failure to meet the McCarran-Ferguson criteria.

The proposed fee schedule amendment is examined under the three McCarran-Ferguson criteria below in order to determine whether the proposed amendment meets the second part of the insurance savings test for a law that “regulates insurance”.

Transferring or Spreading of Risk

A law that regulates the spreading of risk meets the first criterion.⁷²

The spreading and underwriting of a policyholder’s risk are the primary elements of an insurance contract.⁷³ They are an indispensable characteristic of insurance.⁷⁴ “It is characteristic of insurance that a number of risks are accepted, some of which involve losses, and that such losses are spread over all the risks so as to enable the insurer to accept each risk at a slight fraction of the possible liability upon it.”⁷⁵ The transfer of risk from insured to insurer is effected by means of the insurance policy between the parties, and that transfer is complete at the time that the contract is entered.⁷⁶

In *Washington Physicians*, the Ninth Circuit Court of Appeals, citing the Fourth Circuit Court of Appeals, stated that:

Risk-spreading is a concept that involves more than the mere selection of certain medical conditions for coverage. The degree of risk-spreading between the insured and the carrier also depends on what kinds of treatments the policy agrees to pay for, what

70. *Washington Physicians*, 147 F.3d at 1047.

71. It appears that the McCarran-Ferguson criteria are not conjunctive criteria in the Sixth Circuit (*Community Health Partners*, 14 F.Supp.2d at 1001) as well. In contrast, they are conjunctive in the Fifth (*CIGNA Healthplan of Louisiana*, 82 F.3d at 650; *Texas Pharmacy Ass’n*, 105 F.3d at 1038); and Eleventh (*Blue Cross and Blue Shield of Alabama*), 917 F.Supp. at 1539) circuits.

72. *Metropolitan Life Ins Co.*, 471 U.S. at 743.

73. *Royal Drug*, 440 U.S. at 211.

74. *Id.* at 212; *Pireno*, 458 U.S. at 127.

75. *Royal Drug*, 440 U.S. at 211, citing 1 G. Couch, *Cyclopedia of Insurance Law* section 1:3 (2d ed. 1959).

76. *Pireno*, 458 U.S. at 130, citing 9 G. Couch, *Cyclopedia of Insurance Law* sections 39:53, 39:63 (2d ed. 1962).

kinds of deductibles it will charge, and whether there will be a cap on overall expenses.⁷⁷

The Fourth Circuit itself had also said that components to the policyholder's risk included the types of illness and injury that the insurance contract covers, provision for treatment, and the cost of treatment.⁷⁸

In other words, the selection of medical conditions for coverage, the kinds of treatment covered under the policy, and the cost of treatment, including whether there will be cap on overall expenses, are part of the policyholder's risk, and thus, affects risk-spreading.

Here, from a lay perspective of the actuarial concept of risk-spreading, the use of a fee schedule appears to affect risk-spreading between the insured and the insurer because it affects one of the components of the policyholder's risk. Specifically, the fee schedule impacts the costs of treatment. It sets individual caps on the charges for treatments listed under the fee schedule.

The fee schedule amendment meets the first criterion.

Integral Part of the Insurer-Insured Policy Relationship

A law that directly regulates an integral part of the relationship between the insurer and the policyholder meets the second criterion.⁷⁹

The Supreme Court has stated that the core of the "business of insurance" is the "relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement."⁸⁰ At the core then is the insurance policy. Thus, the mandated benefits statute at issue in *Metropolitan Life* directly regulated an integral part of the policy relationship because it limited the type of insurance that an insurer may sell to the policyholder.⁸¹

The Ninth Circuit Court of Appeals in *Washington Physicians* held that a state law regulates an integral part of the carrier-insured relationship if the state law spreads risk and confers a benefit on insureds.⁸² The Ninth Circuit stated that the alternative provider statute spreads risk because it requires policies to cover the services of additional categories of

77. *Washington Physicians*, 147 F.3d at 1046, 1047, citing *Stuart Circle Hosp. Corp.*, 995 F.2d at 503.

78. *Stuart Circle*, 995 F.2d at 503.

79. *Metropolitan Life Ins Co.*, 471 U.S. at 743.

80. *Royal Drug*, 440 U.S. at 215-216, quoting *SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969); *Pireno*, 458 U.S. at 128.

81. *Metropolitan Life Ins. Co.*, 471 U.S. at 743.

82. *Washington Physicians*, 147 F.3d at 1047.

providers. It confers a benefit on insureds because it requires policies to cover the services of additional types of providers.

Here, the issues of risk-spreading and benefiting the insured were discussed earlier. Risk-spreading is the first of the McCarran-Ferguson criteria. Benefiting the insured is a factor in the common sense view of insurance regulation. As concluded previously, the fee schedule amendment spreads risk, but does not necessarily confer any benefit on insureds.

The fee schedule amendment does not meet the second criterion.

Limited to Entities Within the Insurance Industry

A statute that imposes requirements only on insurers, with the intent of affecting the policy relationship between the insurer and the policyholder, meets the third criterion.⁸³

The third criterion that the practice be limited to entities within the insurance industry originates in Congress' intent to exempt the insurance industry's cooperative ratemaking efforts from the antitrust laws. Congress believed that it would be difficult for insurance companies to underwrite risks in an informed and responsible way without intra-industry cooperation.⁸⁴ In contrast, arrangements between insurance companies and parties outside the insurance industry do not lie at the center of Congress's concern, especially since such arrangements have the potential to restrain competition in non-insurance markets.⁸⁵

Accordingly, the United States Supreme Court has held that practices that involve parties wholly outside the insurance industry do not meet the third criterion. Specifically, participating provider agreements between insurers and providers which policyholders are basically unconcerned with⁸⁶ do not meet the criterion.⁸⁷ Peer review practice arrangements between insurers and providers to determine whether charges are reasonable and necessary also do not meet the criterion.⁸⁸ On the other hand, the practice affected by the mandated-benefits statute in *Metropolitan Life* meets the criterion. The statute imposes requirements only on insurers, with the intent of affecting the relationship between the insurer and the policyholder.⁸⁹ In other

83. *Metropolitan Life Ins Co.*, 471 U.S. at 743.

84. *Pireno*, 458 U.S. at 129; *Royal Drug*, 440 U.S., at 221.

85. *Pireno*, 458 U.S. at 133.

86. *Royal Drug*, 440 U.S. at 214 note 11. Policyholders were unconcerned with the arrangement because they were obligated to pay a participating pharmacy a predetermined amount for a prescription regardless of the presence or absence of a price fixing agreement.

87. *Royal Drug*, 440 U.S. at 230.

88. *Pireno*, 458 U.S., at 132-134.

89. *Metropolitan Life*, 471 U.S., at 743.

words, the statute there regulated a practice engaged in only by insurers, which was to decide what benefits to offer in a policy.

Among the lower courts, the Ninth Circuit Court of Appeals in *Washington Physicians* stated that the alternative provider statute meets the criterion because the statute does not reach self-insured ERISA plans, which by definition are not within the insurance industry.⁹⁰ Likewise, the other federal circuits, faced with whether the any willing provider statutes meets the third criterion, generally ask whether the law impermissibly imposes those non-discrimination requirements on non-insurer payors as well as on insurers.⁹¹

Here, the issue of whether the fee schedule amendment is limited to insurers was already part of the analysis under the common sense view. As was stated earlier, the amendment imposes requirements not only on insurers, but on health care providers as well. The amendment requires insurers to use a particular fee schedule to reimburse health care providers. However, it also prohibits providers from charging fees that are greater than the fee schedule amounts and requires providers to accept the fee schedule payment as payment in full. Moreover, imposing a fee schedule on providers may have the potential to restrain competition in the provider market for services covered under group health insurance. Fee schedules that are lower than reasonable may prevent providers from obtaining the fee levels that they would otherwise be able to obtain absent the fee schedules or outside of group health insurance.

The fee schedule amendment does not meet the third criterion.

McCarran-Ferguson Conclusion

The fee schedule amendment fails two of the three McCarran-Ferguson criteria. It meets the first criterion but fails the remaining two. First, the fee schedule amendment regulates risk-spreading, because it regulates the cost of treatment, and cost of treatment is a component of risk. Second, it does not directly regulate an integral part of the relationship between the insurer and the policyholder, because although it may spread risk it does not conclusively confer a benefit on the insured. Third, the fee schedule amendment does not impose requirements only on insurers. It imposes requirements on health care providers by placing ceilings on their charges.

The fee schedule amendment thus meets only one of the three McCarran-Ferguson criteria. Although the Ninth Circuit does not require a law to satisfy all three criteria in order to be a law that regulates the “business of insurance”, failure to meet the majority of the criteria suggests that the amendment is not a law that regulates the “business of insurance”.

90. *Washington Physicians*, 147 F.3d at 1044, 1047.

91. *Blue Cross and Blue Shield of Alabama v. Nielsen*, 917 F.Supp. at 1540; *CIGNA Healthplan*, 82 F.3d at 650; *Texas Pharmacy Ass’n*, 105 F.3d at 1038; *Community Health Partners*, 14 F.Supp.2d at 1003-1004; *American Drug Stores*, 973 F.Supp. at 71.

Conclusion

A fee schedule amendment to the health insurance and related statutes does not achieve its purposes as efficiently as an amendment to the Hawaii Prepaid Health Care Act. It will impact all group health insurance policies, both employer and non-employer group policies.

Aside from efficiency, ERISA is still an obstacle. The hypothetical universal fee schedule amendment posited at the beginning of this chapter “relates to” an employee benefit plan so as to become subject to preemption. A law “relates to” an employee benefit plan if it either has “reference to” or has a “connection with” an employee benefit plan. The fee schedule amendment has a “reference to” employee benefit plans. The amendment directly operates on employee benefit plans because group health insurance policies are defined to include employee group policies. The fee schedule amendment also has a “connection with” employee benefit plans. The amendment constitutes an administrative burden placed on employee benefit plans. The amendment directly operates on employee benefit plans and is an administrative burden on them because under the Hawaii Prepaid Health Care Act some prepaid health care plans are required to provide group health insurance to the employees. Accordingly, ERISA preempts the fee schedule unless the fee schedule is saved from preemption as a law that “regulates insurance”.

The fee schedule amendment does not “regulate insurance”. To “regulate insurance” a law must pass both the common-sense view of insurance regulation and the McCarran-Ferguson criteria for practices constituting the “business of insurance”. It fails the common-sense test because the fee schedule amendment regulates health care providers as well as insurers, and does not conclusively confer a benefit on insureds.

It appears to fail the McCarran-Ferguson test because on balance it fails to meet two of the three test criteria. The fee schedule amendment passes the first criterion of spreading policyholder risk, because the fee schedule specifies covered treatments and the costs of those treatments, and treatment and cost are components of risk. The amendment fails the second criterion of being an integral part of the policy between the insurer and the insured, because it does not necessarily confer a benefit on insureds. It fails the third criterion of being limited to entities within the insurance industry, because it imposes requirements on third party health care providers.

Accordingly, since the fee schedule amendment appears to fail both the common sense test and the McCarran-Ferguson test, it is not saved from preemption as a law that “regulates insurance”.

Chapter 7

FINDINGS AND RECOMMENDATIONS

The Bureau finds that it is not feasible to establish common medical fee schedules for the three insurance systems of prepaid health care, motor vehicle insurance, and workers' compensation. The reason is that establishing common fee schedules for general health care either in the Hawaii Prepaid Health Care Act or other insurance laws is legally impermissible under the federal Employee Retirement Income Security Act ("ERISA") of 1974.

For the purposes of this study, the common fee schedules were presumed to be both of the workers' compensation fee schedules, the Medicare fee schedule (raised by ten per cent) and the workers' compensation supplemental medical fee schedule. The reason for the assumption is that until 2000 the motor vehicle insurance laws piggybacked the workers' compensation fee schedules. In other words, common fee schedules were already being followed by two of the three insurance systems under review in this study, motor vehicle insurance and workers' compensation. However, in 2000, Act 138 amended the motor vehicle insurance laws by replacing references to the "workers' compensation schedules" with references only to the "workers' compensation supplemental medical fee schedule". For the purposes of this study and analysis, then, Act 138 was disregarded.

The federal ERISA law preempts amendments to the Hawaii Prepaid Health Care Act that provide for more than the "effective administration" of the Act as it existed on September 2, 1974. Amending that Act to include a fee schedule would be an amendment that provides for more than "effective administration". The reason is that the amendment imposes duties upon prepaid health care plan contractors and health care providers. Specifically, it requires health care plan contractors to use two particular fee schedules in their reimbursement of providers. It also prohibits health care providers from charging more than the fee schedule amounts and requires them to accept payments under the fee schedules as payment in full.

Instead of amending the Hawaii Prepaid Health Care Act, we considered an alternative approach to establish common fee schedules by amending the group health insurance and related statutes. However, this alternative appears headed toward the same result. We believe that establishing common fee schedules through those laws is also legally impermissible under ERISA. The hypothetical universal fee schedule amendment "relates to" an ERISA plan because it has both a "reference to" and a "connection with" an ERISA plan, although either one alone will suffice to establish the relationship. A significant reason why the amendment "relates to" an ERISA plan is that prepaid health care plans are ERISA plans, and prepaid health care plans must provide the employees with group health insurance coverage, unless the plans offer medical services directly.

We also considered an ERISA exemption for state laws that "regulate insurance". However, the fee schedule amendment does not fit that exemption because it appears to fail both parts of the two-part insurance savings test that qualifies it as "insurance" and thus saves it from preemption. It does not fit the first part of the test, which is the common-sense view of insurance

regulation. The amendment cannot be deemed to benefit insureds because it is uncertain that the fee schedules will actually minimize the insured's co-payments or premiums and do so without adversely impacting the quality of provider care or access to provider care. The amendment is also not directed solely at the insurance industry, because it is directed as well at the health care industry. It subjects health care providers to a ceiling on charges.

The amendment also does not appear to fit the second part of the insurance savings test, which is the McCarran-Ferguson criteria for the "business of insurance." It fails two of the three criteria. It passes the first criterion of spreading policyholder risk, because the fee schedule specifies covered treatments and the costs of those treatments. Treatment and cost are components of risk. However, the amendment fails the second criterion of being an integral part of the policy between the insurer and the insured, because it cannot be deemed to confer a benefit on insureds. Further, it fails the third criterion of being limited to entities within the insurance industry, because it imposes requirements on third party health care providers.

For the foregoing reasons, there is no model common medical fee schedule that the Bureau can recommend.

If the Legislature wants to apply a universal fee schedule to the extent permissible, *i.e.*, a common fee schedule applicable to workers' compensation and motor vehicle insurance cases, it can accomplish this by undoing the effects of Act 138, Session Laws of Hawaii 2000.

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H.R. NO.

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H.D. 1

REQUESTING A STUDY ON THE FEASIBILITY OF ESTABLISHING A
UNIVERSAL MEDICAL FEE SCHEDULE FOR THE PREPAID HEALTH
INSURANCE SYSTEM, THE MEDICAL PORTION OF THE NO-FAULT
AUTOMOBILE INSURANCE SYSTEM, AND THE MEDICAL PORTION OF
THE WORKERS' COMPENSATION INSURANCE SYSTEM IN HAWAII, AND
DETERMINING UNIVERSAL PAYMENT POLICIES, RECOGNIZED
PROVIDERS, AND POLICIES REGARDING PAYMENT FOR SUPPLIES.

1 WHEREAS, in Hawaii, health care financing is fragmented
2 and complex where separate, parallel, and often duplicative
3 insurance systems exist, for example, mandatory prepaid health
4 care insurance for employees, workers' compensation, and no-
5 fault automobile insurance for drivers; and

6
7 WHEREAS, three different medical fee schedules are in
8 operation in Hawaii for these three different insurance systems
9 even though the medical services, treatment, or care being
10 provided are either identical or similar in nature; and

11
12 WHEREAS, the medical fee schedule under the medical
13 insurance portion of no-fault automobile insurance is higher
14 than the fee schedule under the employer-based prepaid health
15 care insurance system; and

16
17 WHEREAS, workers' compensation is similarly duplicative,
18 especially for the majority of health benefits that are offered
19 under employees' regular prepaid health plans; and

20
21 WHEREAS, fully forty percent of workers' compensation
22 payments are made for medical claims; and

23
24 WHEREAS, there is no reason why the cost of treating an
25 injury or illness, regardless of the cause, should be different
26 merely because the type of insurance system under which
27 providers are paid is different; and

28
29 WHEREAS, the three separate medical fee schedules used to
30 pay providers under the prepaid health insurance system, the
31 medical portion of the no-fault automobile insurance system,
32 and the medical portion of the workers' compensation insurance
33 system should be consolidated into one universal medical fee
34 schedule; and

35 WHEREAS, the establishment of this universal medical fee
36 schedule does not require an insurer under any of the three
37 insurance systems to cover medical benefits that it does not

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1 already provide; the universal medical fee schedule merely
2 provides one single comprehensive set of payments for medical
3 services, treatment, and care that an insurer provides under
4 any insurance system; and

5
6 WHEREAS, the cost of health insurance is a significant
7 contributor to the cost of living in Hawaii and every effort
8 should be made to streamline and consolidate medical fee
9 schedules paid for the same treatment, care, or service
10 provided under either prepaid health insurance, the medical
11 portion of no-fault automobile insurance, or the medical
12 portion of workers' compensation insurance; now, therefore,

13
14 BE IT RESOLVED by the House of Representatives of the
15 Twentieth Legislature of the State of Hawaii, Regular Session
16 of 2000, that the Legislative Reference Bureau (LRB) is
17 requested to study the feasibility of:

- 18
19 (1) Establishing a universal medical fee schedule for the
20 prepaid health insurance system, the medical portion
21 of the no-fault automobile insurance system, and the
22 medical portion of the workers' compensation
23 insurance system in Hawaii; and
24
25 (2) Determining universal payment policies, recognized
26 providers, and policies regarding payment for
27 supplies.
28

29 BE IT FURTHER RESOLVED that, if the LRB finds that it is
30 feasible to implement a universal medical fee schedule in
31 Hawaii, the LRB is requested to include in its report, to the
32 extent possible, a suggested model universal medical fee
33 schedule; and
34

35 BE IT FURTHER RESOLVED that the LRB is requested to submit
36 a report to the Legislature no later than twenty days prior to
37 the convening of the Regular Session of 2001; and
38

39 BE IT FURTHER RESOLVED that certified copies of this
40 Resolution be transmitted to the Acting Director of LRB, the
41 Director of Commerce and Consumer Affairs, and the Insurance
42 Commissioner.